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IMMIGRATION NURSING RELIEF ACT OF 1989

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HEARING

BEFORE THE

SUBCOMMITTEE ON IMMIGRATION, REFUGEES,
AND INTERNATIONAL LAW

OF THE

COMMITTEE ON THE JUDICIARY
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

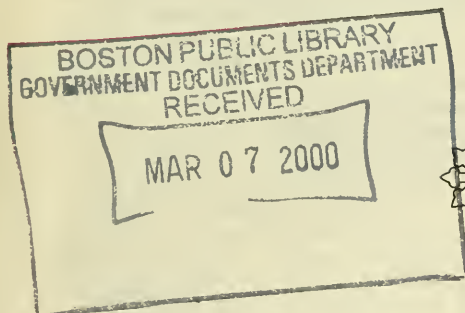
ON

H.R. 1507 and H.R. 2111

IMMIGRATION NURSING RELIEF ACT OF 1989

MAY 31, 1989

Serial No. 13



Printed for the use of the Committee on the Judiciary

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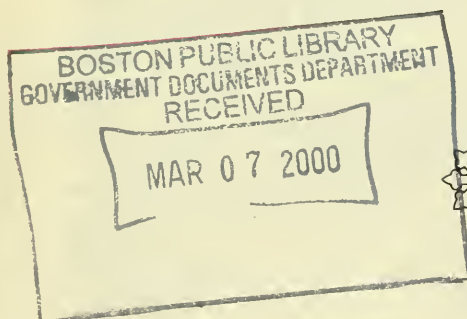
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IMMIGRATION NURSING RELIEF ACT OF 1989

WEDNESDAY, MAY 31, 1989

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON IMMIGRATION, REFUGEES,
AND INTERNATIONAL LAW,
COMMITTEE ON THE JUDICIARY,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:10 a.m., in room 2237, Rayburn House Office Building, Hon. Bruce A. Morrison (chairman of the subcommittee) presiding.

Present: Representatives Bruce A. Morrison, Charles E. Schumer, Lamar S. Smith, and Hamilton Fish, Jr.

Also present: Mary Rae McGillis, legislative assistant; Bernadette Maguire, legislative assistant; Debra James-Morris, clerk; and Margaret L. Webber, minority counsel.

OPENING STATEMENT OF CHAIRMAN MORRISON

Mr. MORRISON. The hearing will come to order.

I would like to open this hearing of the Subcommittee on Immigration, Refugees, and International Law. We have noticed for hearing two particular bills, H.R. 1507 introduced by a member of the subcommittee, Mr. Schumer, and H.R. 2111 by Congressman Gary Ackerman, who is going to be our first witness.

[The bills, H.R. 1507 and H.R. 2111, follow:]

101ST CONGRESS
1ST SESSION

H. R. 1507

To amend the Immigration and Nationality Act to provide for special immigrant status for certain H-1 nonimmigrant nurses and to establish conditions for the admission, during a 5-year period, of nurses as temporary workers.

IN THE HOUSE OF REPRESENTATIVES

MARCH 20, 1989

Mr. SCHUMER (for himself, Mr. HUGHES, Mr. MOLINARI, Mr. GARCIA, Mr. MEAZEK, Mr. SAXTON, Mr. BATES, Mr. DORNAN of California, Mr. GILMAN, Mr. STUDDS, Mr. FOGLIETTA, Mr. MARTIN of New York, Mr. ACKERMAN, Mr. DYMALLY, Mr. FLORIO, Mr. ATKINS, Mrs. COLLINS, Mr. GALLO, Mr. MCGRATH, Mr. FAZIO, Mrs. ROUKEMA, and Mr. RIDGE) introduced the following bill; which was referred to the Committee on the Judiciary

A BILL

To amend the Immigration and Nationality Act to provide for special immigrant status for certain H-1 nonimmigrant nurses and to establish conditions for the admission, during a 5-year period, of nurses as temporary workers.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the "Immigration Nursing
5 Relief Act of 1989".

1 SEC. 2. SPECIAL IMMIGRANT STATUS FOR CERTAIN H-1 NON-
2 IMMIGRANT NURSES.

3 Section 101(a)(27) of the Immigration and Nationality
4 Act (8 U.S.C. 1101(a)(27)) is amended—

5 (1) by striking “or” at the end of subparagraph
6 (H),

7 (2) by striking the period at the end of subpara-
8 graph (I) and inserting “; or”, and

9 (3) by adding at the end the following new sub-
10 paragraph:

11 “(J) an immigrant, and his accompanying spouse
12 and children—

13 “(i) who entered the United States before
14 January 1, 1988, as a nonimmigrant under para-
15 graph (15)(H)(i) to perform services as a regis-
16 tered nurse,

17 “(ii) whose visa as such a nonimmigrant had
18 not expired as of the date of the enactment of this
19 subparagraph (including an alien whose status
20 was extended under section 4 of the Immigration
21 Amendments of 1988 (Public Law 100-658)) and
22 who is employed as a registered nurse as of such
23 date, and

24 “(iii) with respect to whose employment as a
25 registered nurse there is a certification made
26 under section 212(a)(14) before the date the immi-

1 grant is granted special immigrant status under
2 this subparagraph.”.

3 **SEC. 3. REQUIREMENTS FOR ADMISSION OF NONIMMIGRANT**
4 **NURSES DURING 5-YEAR PERIOD.**

5 (a) **ESTABLISHMENT OF A NEW NONIMMIGRANT**
6 **CLASSIFICATION FOR NONIMMIGRANT NURSES.**—Section
7 101(a)(15)(H) of the Immigration and Nationality Act (8
8 U.S.C. 1101(a)(15)(H)) is amended—

9 (1) in clause (i), by inserting “(other than services
10 as a registered nurse)” after “to perform services” the
11 first place it appears, and

12 (2) by inserting before “and the alien spouse” the
13 following: “or (iv) who is coming temporarily to the
14 United States to perform services as a registered
15 nurse, who meets the qualifications described in section
16 212(m)(1), and with respect to whom the Secretary of
17 Labor determines and certifies to the Attorney General
18 that the conditions described in section 212(m)(2) have
19 been met with respect to the facility for which the
20 alien will perform the services;”.

21 (b) **REQUIREMENTS.**—Section 212 of such Act (8
22 U.S.C. 1182) is amended by adding at the end the following
23 new subsection:

24 “(m)(1) The qualifications referred to in section
25 101(a)(15)(H)(iv), with respect to an alien who is coming to

1 the United States to perform nursing services for a facility,
2 are that the alien—

3 “(A) has obtained a full and unrestricted license
4 to practice professional nursing in the country where
5 the alien obtained nursing education or has received
6 nursing education in the United States or Canada;

7 “(B) has passed an appropriate examination (rec-
8 ognized in regulations promulgated in consultation with
9 the Secretary of Health and Human Services) or is li-
10 censed under State law to practice professional nursing
11 in the State of intended employment; and

12 “(C) is fully qualified and eligible under the laws
13 governing the place of intended employment to engage
14 in the practice of professional nursing as a registered
15 nurse immediately upon admission to the United States
16 and is authorized under such laws to be employed by
17 the facility;

18 except that subparagraph (C) shall not apply to the extent
19 that State or local laws limit the services that may be provid-
20 ed by such an alien, if the alien will not be employed to
21 provide nursing services in violation of such a law.

22 “(2)(A) The conditions referred to in section
23 101(a)(15)(H)(iv), with respect to a facility for which an alien
24 will perform services, are that—

1 “(i) there would be a substantial disruption
2 through no fault of the facility in the delivery of health
3 care services of the facility without the services of such
4 an alien;

5 “(ii) the employment of the alien will not adverse-
6 ly affect the wages and working conditions of regis-
7 tered nurses similarly employed and the alien will be
8 paid at the prevailing wage rate for registered nurses
9 similarly employed by the facility;

10 “(iii) the facility has demonstrated that it has
11 taken and is taking timely and significant steps de-
12 signed to recruit and retain sufficient registered nurses
13 who are United States citizens or immigrants who are
14 authorized to perform nursing services, in order to
15 remove as quickly as reasonably possible the depend-
16 ence of the facility on nonimmigrant registered nurses;

17 “(iv) there is not a strike or lockout in the course
18 of a labor dispute which, under regulations of the Sec-
19 retary, precludes approval, and the facility certifies
20 that the employment of such an alien is not intended or
21 designed to influence an election for a bargaining rep-
22 resentative for registered nurses of the facility; and

23 “(v) at the time of the filing of the petition for
24 registered nurses under section 101(a)(15)(H)(iv), notice
25 of the filing has been provided to the bargaining repre-

1 sentative of the registered nurses at the facility or,
2 where there is no such bargaining representative,
3 notice of the filing has been provided to registered
4 nurses employed at the facility through posting in con-
5 spicuous locations.

6 Nothing in clause (iii) shall be construed as requiring a facili-
7 ty to have taken significant steps described in such clause
8 before the date of the enactment of this subsection.

9 “(B)(i) Except as provided in clause (ii), a facility is con-
10 sidered to have met the condition described in subparagraph
11 (A)(i) if it is located in an urban area which the Secretary of
12 Labor determines has a significant shortage of registered
13 nurses.

14 “(ii) Clause (i) shall not apply to a particular facility
15 during the 1 year period beginning on the date on which the
16 facility has laid off registered nurses. The previous sentence
17 shall not apply to the firing of registered nurses for good
18 cause shown.

19 “(iii) In clause (i), the term ‘urban area’ means a Metro-
20 politan Statistical Area or New England County Metropoli-
21 tan Area (as defined by the Office of Management and
22 Budget) .

23 “(C) For purposes of subparagraph (A)(iii), each of the
24 following shall be considered a significant step reasonably de-
25 signed to recruit and retain registered nurses:

1 “(i) Operating a training program for registered
2 nurses at the facility or providing an opportunity for
3 training for registered nurses elsewhere.

4 “(ii) Paying registered nurses at wages at a rate
5 above the prevailing wage rate for registered nurses in
6 the geographic area.

7 “(iii) Providing adequate support services to free
8 registered nurses from administrative and other non-
9 nursing duties.

10 “(iv) Providing reasonable opportunities for mean-
11 ingful salary advancement by registered nurses.

12 The steps described in this subparagraph shall not be consid-
13 ered to be an exclusive list of the significant steps that may
14 be taken to meet the conditions of subparagraph (A)(iii).

15 “(D) A certification to be made with respect to the con-
16 ditions described in this paragraph shall—

17 “(i) subject to clauses (ii) through (iv), be valid for
18 a period of 1 year,

19 “(ii) apply to petitions filed during such 1-year
20 period if the facility certifies in each such petition that
21 it continues to comply with such conditions, and

22 “(iii) be revoked by the Secretary of Labor upon a
23 finding that the facility for which the certification is
24 made no longer meets such conditions or upon a find-

1 ing that there was a misrepresentation of material fact
2 in the application for certification.

3 “(E) A facility may meet the requirements under this
4 paragraph with respect to more than one registered nurse in
5 a single petition.

6 “(3) The period of admission of an alien under section
7 101(a)(15)(H)(iv) shall be for an initial period of not to exceed
8 3 years, subject to an extension for a period or periods, not to
9 exceed a total period of admission of 5 years (or a total period
10 of admission of 6 years in the case of extraordinary circum-
11 stances, as determined by the Attorney General).

12 “(4) For purposes of this subsection and section
13 101(a)(15)(H)(iv), the term ‘facility’ includes an employer
14 who employs registered nurses in a home setting.”.

15 (c) IMPLEMENTATION.—The Secretary of Labor
16 shall—

17 (1) first publish final regulations to carry out sec-
18 tion 212(m)(2)(A) of the Immigration and Nationality
19 Act (as added by this section) not later than the first
20 day of the 8th month beginning after the date of the
21 enactment of this Act;

22 (2) provide for the appointment (by January 1,
23 1991) of an advisory group, including representatives
24 of the Secretary, the Secretary of Health and Human
25 Services, the Attorney General, hospitals, and labor

1 organizations representing registered nurses, to advise
2 the Secretary—

3 (A) concerning the impact of this legislation
4 on the nursing shortage,

5 (B) on programs that medical institutions
6 may implement to recruit and retain registered
7 nurses who are United States citizens or immi-
8 grants who are authorized to perform nursing
9 services, and

10 (C) on the advisability of extending the pro-
11 visions of the amendments made by this section
12 beyond the 5-year period described in subsection
13 (d); and

14 (3) conduct a study, and report to Congress on
15 the study not later than January 1, 1992, concerning
16 the impact of the amendments made by this section.

17 (d) LIMITING APPLICATION OF NONIMMIGRANT
18 CHANGES TO 5-YEAR PERIOD.—The amendments made by
19 this section shall apply to classification petitions filed for non-
20 immigrant status only during the 5-year period beginning on
21 the first day of the 9th month beginning after the date of the
22 enactment of this Act.

○

101ST CONGRESS
1ST SESSION

H. R. 2111

To amend the Public Health Service Act to establish programs to increase the supply of professional nurses and provide educational assistance to nurses, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

APRIL 26, 1989

Mr. ACKERMAN (for himself, Mr. RANGEL, Mr. FAZIO, Mr. FAUNTROY, Mr. FOGLIETTA, Mr. DYMALLY, Mr. DE LUGO, Mr. MANTON, Mr. YATES, Mr. MCGRATH, Mr. THOMAS A. LUKE, Mr. MORRISON of Connecticut, Mr. DWYER of New Jersey, Mr. NEAL of Massachusetts, Mr. ENGEL, Mr. EVANS, Mr. BUSTAMANTE, Mr. FLORIO, Mr. LEWIS of Georgia, Mr. TORRES, Mr. KILDEE, Ms. KAPTUR, Mr. MRAZEK, Mr. ECKART, Mr. WEISS, and Mr. TOWNS) introduced the following bill; which was referred jointly to the Committees on Energy and Commerce, Ways and Means, and the Judiciary

A BILL

To amend the Public Health Service Act to establish programs to increase the supply of professional nurses and provide educational assistance to nurses, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 SECTION 1. SHORT TITLE.

4 This Act may be cited as the "Emergency Nurse
5 Shortage Relief Act of 1989".

1 SEC. 2. GRANTS FOR PROGRAMS TO INCREASE NUMBER OF
2 ACTIVE NURSES.

3 Subpart I of part A of title VIII of the Public Health
4 Service Act (42 U.S.C. 296k et seq.) is amended by adding
5 at the end the following new section:

6 "NURSE RECRUITMENT PROGRAMS

7 "SEC. 823. (a) IN GENERAL.—The Secretary may
8 make grants to public and nonprofit private entities to carry
9 out programs—

10 "(1) to promote nursing as a career choice and to
11 educate the public regarding the value of the nursing
12 profession;

13 "(2) to identify students in public secondary
14 schools who show an interest in health care and pro-
15 vide such students with internships in the area of
16 health care;

17 "(3) to promote the nursing profession in public
18 secondary schools; and

19 "(4) to recruit nursing students, by using creative
20 methods, from groups not traditionally well represented
21 in the nursing profession, including men, minorities,
22 and individuals who are pursuing a second career.

23 "(b) APPLICATION.—To receive a grant under this sec-
24 tion, a public or private nonprofit entity shall submit an appli-
25 cation to the Secretary as the Secretary may require.

1 “(c) AUTHORIZATION OF APPROPRIATIONS.—There
 2 are authorized to be appropriated such sums as may be nec-
 3 essary to carry out this section. Any amounts appropriated
 4 under this section shall remain available until expended.”.

5 SEC. 3. GRANTS FOR PROGRAMS TO ATTRACT INACTIVE
 6 NURSES BACK INTO NURSING PROFESSION.

7 Subpart I of part A of title VIII of the Public Health
 8 Service Act (42 U.S.C. 296k et seq.), as amended by section
 9 2 of this Act, is further amended by adding at the end the
 10 following new section:

11 “INACTIVE NURSE REACTIVATION AND TRAINING
 12 PROGRAMS

13 “SEC. 824. (a) IN GENERAL.—The Secretary may
 14 make grants to public and private nonprofit entities and
 15 schools of nursing to establish or assist programs—

16 “(1) to encourage and assist nurses that are not
 17 practicing in the nursing profession to reenter the
 18 profession;

19 “(2) to train or educate nurses that are reentering
 20 the nursing profession and practicing nurses as nurse
 21 practitioners or nurse midwives or in areas of needed
 22 specialized nursing skills (as determined by the Secre-
 23 tary under section 860(a)(2)) to; and

24 “(3) to provide tuition assistance to students en-
 25 rolled in educational programs designed to facilitate the

1 reentry into the nursing profession of nurses that are
2 not practicing in the nursing profession.

3 “(b) APPLICATION.—To receive a grant under this sec-
4 tion, a public or private nonprofit entity or a school of nurs-
5 ing shall submit an application to the Secretary as the Secre-
6 tary may require.

7 “(c) AUTHORIZATION OF APPROPRIATIONS.—There
8 are authorized to be appropriated such sums as may be nec-
9 essary to carry out this section. Any amounts appropriated
10 under this section shall remain available until expended.”.

11 **SEC. 4. GRANTS FOR PROGRAMS TO RETAIN PRACTICING**
12 **NURSES.**

13 Subpart I of part A of title VIII of the Public Health
14 Service Act (42 U.S.C. 296k et seq.), as amended by sections
15 2 and 3 of this Act, is further amended by adding at the end
16 the following new section:

17 **“PRACTICING NURSE RETENTION PROGRAMS**

18 **“SEC. 825. (a) IN GENERAL.** The Secretary may make
19 grants to health care facilities to carry out programs—

20 **“(1)** to demonstrate the use of innovative methods
21 to increase the attractiveness to individuals of the nurs-
22 ing profession as a career choice through changes in
23 traditional wage structures, flexible delivery and sched-
24 uling of employment options and benefits, and restruc-
25 turing the role of nurses in the health care facilities;
26 and

1 “(2) to demonstrate innovative methods of provid-
2 ing for advancement in careers in the nursing profes-
3 sion to encourage nurses and nurse assistants to con-
4 tinue education in nursing.

5 “(b) APPLICATION.—To receive a grant under this sec-
6 tion, a health care facility shall submit an application to the
7 Secretary as the Secretary may require.

8 “(c) DEFINITION OF HEALTH CARE FACILITY.—For
9 purposes of this section, the term ‘health care facility’ means
10 a hospital, public health center, outpatient medical facility,
11 rehabilitation facility, facility for long-term care, or other fa-
12 cility for the provision of health care services.

13 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
14 are authorized to be appropriated such sums as may be nec-
15 essary to carry out this section. Any amounts appropriated
16 under this section shall remain available until expended.”.

17 **SEC. 5. PROGRAM FOR LOANS FOR CONTINUED NURSE TRAIN-**
18 **ING AND LOAN FORGIVENESS TO NURSING**
19 **STUDENTS.**

20 Part B of title VIII of the Public Health Service Act
21 (42 U.S.C. 297 et seq.) is amended by adding at the end the
22 following new subpart:

1 "Subpart V—Assistance for Nurses After Completion of
2 Nursing School

3 "LOANS FOR CONTINUED NURSE TRAINING

4 "SEC. 849. (a) ESTABLISHMENT OF PROGRAM.—The
5 Secretary may establish a program to insure educational
6 loans to individuals who have attained a degree as a regis-
7 tered nurse for educational expenses related to programs de-
8 signed to train or educate nurses as nurse practitioners or
9 nurse midwives or in areas of needed specialized nursing
10 skills (as designated by the Secretary under section
11 860(a)(2)).

12 "(b) ORGANIZATION OF PROGRAM.—With respect to
13 the Federal Program of Insured Loans to Graduate Students
14 in Health Professions Schools established in subpart I of part
15 C of title VII, the provisions of such subpart shall, except as
16 inconsistent with this section, apply to the program estab-
17 lished under subsection (a) in the same manner and to the
18 same extent as such provisions apply to the Federal Program
19 of Insured Loans to Graduate Students in Health Professions
20 Schools.

21 "(c) BUDGET COMPLIANCE.—The authority of the Sec-
22 retary to insure loans under this section shall be effective for
23 any fiscal year only to such extent or in such amounts as are
24 provided in appropriation Acts."

1 “STUDENT LOAN FORGIVENESS PROGRAM

2 “SEC. 846. (a) ESTABLISHMENT.—The Secretary may
3 carry out a program to enter into agreements with eligible
4 individuals to assist in repaying, in the amounts specified in
5 subsection (c), the eligible educational loans of the eligible
6 individuals.

7 “(b) ELIGIBLE BORROWERS.—An individual shall be
8 eligible to receive assistance under this section if the
9 individual—

10 “(1)(A) is enrolled as a full-time student in a col-
11 legiate school of nursing in a program leading to the
12 achievement of a degree as a registered nurse; and

13 “(B) agrees, to the satisfaction of the Secretary,
14 to work full time as a registered nurse in a nursing
15 crisis area (as designated by the Secretary under sec-
16 tion 860(a)(1)); or

17 “(2)(A) has attained a degree as a registered
18 nurse;

19 “(B) is enrolled in a program designed to train or
20 educate the individual as a nurse practitioner or nurse
21 midwife or regarding an area of a needed specialized
22 nursing skill (as designated by the Secretary under sec-
23 tion 860(a)(2)); and

24 “(C) agrees, to the satisfaction of the Secretary,
25 to work full time after completion of the program as a

1 registered nurse in a nursing crisis area (as designated
2 by the Secretary under section 860(a)(1)) in a position
3 that utilizes such training or education.

4 “(c) AMOUNT OF PAYMENTS.—The program estab-
5 lished by the Secretary under this section may pay to a
6 holder of loans on behalf of an eligible individual, for each
7 completed 12-month period of work as agreed to under para-
8 graph (1)(B) or (2)(C) of subsection (b), an amount equal to
9 the amount equal to the percentage of the total of the princi-
10 pal, interest, and related expenses of such educational loans
11 of the eligible individual determined in accordance with the
12 following table:

“Years of work completed as agreed to as a full-time registered nurse in a nursing crisis area	Percentage of total of principal, interest, and related expenses of eligible loans repaid under this section for previous 12-month period	Cumulative percentage of total of principal, interest, and related expenses of eligible loans repaid under this section
1.....	20	20
2.....	20	40
3.....	45	85
4.....	15	100

13 “(d) DEFINITION OF ELIGIBLE EDUCATIONAL
14 LOANS.—For purposes of this section the term ‘eligible edu-
15 cational loan’ means—

16 “(1) for an individual eligible under subsection
17 (b)(1), any educational loans received before the attain-

1 ment by the individual of the position of registered
2 nurse; and

3 “(2) for an individual eligible under subsection
4 (b)(2), any educational loans relating to the program in
5 which the individual participates pursuant to subpara-
6 graph (B) of such subsection.

7 “(e) BUDGET COMPLIANCE.—The authority of the Sec-
8 retary to enter into agreements under this section to repay
9 loans shall be effective for any fiscal year only to such extent
10 or in such amounts as are provided in appropriation Acts.”.

11 **SEC. 6. INCOME TAX CREDIT FOR CORPORATIONS WHICH**
12 **PROVIDE SCHOLARSHIPS FOR NURSE TRAIN-**
13 **ING.**

14 (a) IN GENERAL.—Subpart B of part IV of subchapter
15 A of chapter 1 of the Internal Revenue Code of 1986 (relat-
16 ing to foreign tax credit, etc.) is amended by adding at the
17 end thereof the following new section:

18 **“SEC. 30. SCHOLARSHIPS PROVIDED BY CORPORATIONS FOR**
19 **NURSE TRAINING.**

20 “(a) ALLOWANCE OF CREDIT.—In the case of a C cor-
21 poration, there shall be allowed as a credit against the tax
22 imposed by this chapter for the taxable year an amount equal
23 to 20 percent of the amount paid or incurred by the taxpayer
24 during the taxable year as qualified nursing scholarships.

1 “(b) QUALIFIED NURSING SCHOLARSHIP DEFINED.—

2 For purposes of this section, the term ‘qualified nursing
3 scholarship’ means any scholarship—

4 “(1) which is excludable from the gross income of
5 the recipient, and

6 “(2) which is received by an individual who is a
7 candidate for a degree as a registered nurse or for a
8 higher nursing degree for purposes of pursuing such a
9 degree.

10 “(c) APPLICATION WITH OTHER CREDITS.—The
11 credit allowed by subsection (a) for any taxable year shall not
12 exceed the excess (if any) of—

13 “(1) the regular tax for the taxable year reduced
14 by the sum of the credits allowable under subpart A
15 and sections 27, 28, and 29, over

16 “(2) the tentative minimum tax for the taxable
17 year.”

18 (b) CLERICAL AMENDMENT.—The table of sections for
19 such subpart B is amended by adding at the end thereof the
20 following new item:

“Sec. 30. Scholarships provided by corporations for nurse training.”

21 (c) EFFECTIVE DATE.—The amendments made by this
22 section shall apply to amounts paid or incurred after the date
23 of the enactment of this Act, in taxable years ending after
24 such date.

1 SEC. 7. EXTENSION OF H-1 VISAS FOR REGISTERED NURSES
 2 IN NURSING CRISIS AREAS.

3 (a) IN GENERAL.—In the case of an alien admitted as a
 4 nonimmigrant under section 101(a)(15)(H)(i) of the Immigra-
 5 tion and Nationality Act to perform temporarily services as a
 6 registered nurse in a nursing crisis area (as designated by the
 7 Secretary of Health and Human Services under section
 8 860(a)(1) of the Public Health Service Act), upon completion
 9 of 5 years in such status the Attorney General shall provide
 10 for the extension of such status for at least an additional year
 11 if the conditions in subsection (b) are met.

12 (b) CONDITIONS FOR EXTENSION.—The Attorney Gen-
 13 eral shall not provide for an extension of status under this
 14 section for an alien unless the Secretary of Labor has certi-
 15 fied that the continuing employment of the alien will not ad-
 16 versely affect the wages and working conditions of registered
 17 nurses in the United States.

18 SEC. 8. DESIGNATION OF NURSING CRISIS AREAS AND AREAS
 19 OF SPECIALIZED NURSING SKILLS.

20 Part C of title VIII of the Public Health Service Act
 21 (42 U.S.C. 851 et seq.) is amended by adding at the end the
 22 following new section:

23 “DESIGNATION OF NURSING CRISIS AREAS AND AREAS OF
 24 NEEDED SPECIALIZED NURSING SKILLS

25 “SEC. 860. (a) DESIGNATION.—

1 “(1) NURSING CRISIS AREAS.—The Secretary
2 shall designate geographic areas (which need not con-
3 form to the geographic boundaries of any existing polit-
4 ical subdivisions) that have, in the determination of the
5 Secretary, a severe shortage in the number of nurses
6 necessary to adequately serve the health needs of the
7 area, as nursing crisis areas.

8 “(2) AREAS OF NEEDED SPECIALIZED NURSING
9 SKILLS.—The Secretary shall designate as areas of
10 needed specialized nursing skills areas or fields of nurs-
11 ing skill or expertise in which, in the determination of
12 the Secretary, there are a shortage of practicing nurses
13 necessary to adequately serve the health needs of per-
14 sons demanding nurses with such skills or expertise.”.

15 “(b) ANNUAL REDESIGNATION.—The Secretary shall
16 review at least annually the designations made under subsec-
17 tion (a), and shall, if necessary in the discretion of the Secre-
18 tary, redesignate nursing crisis areas and areas of needed
19 specialized nursing skills under subsection (a).”.

20 **SEC. 9. EFFECTIVE DATE.**

21 Except as provided in section 6(c), this Act and the
22 amendments made by this Act shall take effect upon the expi-
23 ration of the 90-day period beginning on the date of the en-
24 actment of this Act.

Mr. MORRISON. The purpose of this hearing is twofold. Narrowly, it is to look at the issue of the supply of nurses and the issue of the extent to which the nursing shortage is being responded to by foreign nurses at this time, what ought to be done to prevent an increase in the nursing shortage by the impact of the immigration laws, and to look down the road with respect to the nursing profession and the way in which temporary or permanent admissions based on labor certification or labor skills or labor standards of some kind is an appropriate source of nursing supply.

But the purpose of this hearing is also broader, which is to look at the issue of nurses as an example of a labor shortage problem having been responded to by temporary admissions under our immigration laws and to seek to discover how our generic laws with respect to labor admissions ought to be modified, if they should be modified, to respond to such problems since we read regularly in the media of labor shortages in a wide range of areas not limited to nursing.

It is the intention of the subcommittee to hold extensive hearings on a variety of issues in legal immigration, and both temporary and permanent admission based on skills and based on labor needs are on the agenda for those hearings. So we expect to not only learn about the viability of these two pieces of legislation but learn more about the appropriateness of labor-based admissions, both temporarily and permanently, as part of our immigration laws.

We will need to make a determination as to the extent to which we should act immediately on the nurses problem and the extent to which the general problem ought to subsume that of the nurses. December 31 of this year marks the expiration of previous emergency legislation, and there is a need to determine whether some extension of that legislation or modification of it is appropriate.

So it is with that both narrow and broad focus that we will be pursuing this hearing, and we look forward to the testimony.

I would yield now to the gentleman from Texas, Mr. Smith.

Mr. SMITH of Texas. Thank you, Mr. Chairman.

Like you, I look forward to hearing from the witnesses today on the issue of foreign nurses and the lack of supply of professional nurses, specifically H.R. 1507 and H.R. 2111.

As my colleagues know, currently the United States is facing an extraordinary nursing shortage. Although the exact size of this shortage is unknown, thousands, perhaps 200,000, nursing positions are unfilled in our hospitals and nursing homes across the Nation. Within our health care systems, nursing skills and professional nurses' organizations are working to find solutions to this crisis.

Because of the severe shortage, our health care facilities have found it necessary to recruit medical personnel and nurses from abroad. Today, thousands of foreign nurses are employed throughout the Nation and are providing professional health care services for our communities. Many community hospitals throughout the country have suffered substantial disruption in the delivery of health care services, causing some to close beds and others whole floors because of the shortage.

On May 26 last year, the Immigration and Naturalization Service, aware of this critical problem, announced that all foreign nurses then in the United States on H-1 visas, whose visas had ex-

pired, would be granted an extension of 1 year in the United States, thus allowing them to stay a total of 6 years. In addition, Congress passed legislation last year to further extend this H-1 visa for an additional year, ending December 1989.

While this did not provide a permanent solution to our problem, it did provide some short-term relief and enabled health care professional and administrative agencies and interest groups to further examine both long-term and short-term solutions to this critical problem.

The hearing today will provide us an opportunity to examine the problem in detail as well as consider possible solutions.

I look forward to hearing the testimony and welcome our witnesses, and, Mr. Chairman, I would like to give a special thanks to a friend of mine from San Antonio representing the University of Texas School of Nursing, Ruth Stewart, who will be on the second panel with us today. She is a personal friend, a practicing nurse, and someone whose judgment I very much respect.

Thank you, Mr. Chairman.

Mr. MORRISON. Thank you, Mr. Smith.

Now, for an opening statement, I recognize the gentleman from New York, Mr. Schumer, who is the prime sponsor of one of the two bills that the committee will be hearing about today.

Mr. SCHUMER. Thank you very much, Mr. Chairman.

First, let me welcome my friend and colleague, Gary Ackerman, who is an outstanding legislator. I am glad that we are thinking alike on this, as we do on so many other issues.

Mr. Chairman, I want to thank you for holding this hearing today on a topic that is timely, tragic, and of great concern to our Nation. The shortage of registered nurses is real, widespread, and of significant magnitude—that is a quote—according to a recent report of the Secretary's Commission on Nursing. The Commission found that in hospitals and nursing homes alone there are 137,000 vacant positions for nurses. The shortage is nationwide.

We will hear testimony today about the dire needs of California, Texas, Florida, and New York hospitals for health care services. The shortage has neither spared urban nor rural hospitals and has swept across all forms of nursing services. It is no exaggeration to state that in New York City health care is on the brink of a disaster. The loss of 1,000 foreign-trained nurses could push the city over the edge.

I am trying to abbreviate here. My staff is very good at 15-minute opening statements.

Mr. MORRISON. The gentleman's complete written statement will be made part of the record, without objection.

Mr. SCHUMER. Thank you.

Anyway, there are lots of problems in New York, New Jersey—

Mr. MORRISON. Are some of those in New York in Brooklyn?

Mr. SCHUMER [continuing]. California.

H.R. 1507 would permit nurses to remain in the United States as permanent residents. At the same time, it would build in protections for U.S. workers and require facilities to take steps to recruit and retain U.S. nurses.

H.R. 1507 is not a panacea for the nursing shortage, but in the short term it will stop the hemorrhaging. In the long term, it will require facilities to implement measures to make the profession more appealing and accessible to U.S. labor.

I look forward to hearing the testimony of our distinguished witnesses this morning on this urgent matter, and I appreciate the chairman making the whole statement part of the record.

[The prepared statement of Mr. Schumer follows:]

STATEMENT OF REPRESENTATIVE CHARLES E. SCHUMER
REGARDING THE NURSING SHORTAGE

Hearing before the Subcommittee on Immigration, Refugees
and International Law
May 31, 1989

Mr. Chairman, I want to thank you for holding this hearing today on a topic that is timely, tragic, and of great concern to our nation.

The shortage of registered nurses is "real, widespread, and of significant magnitude," according to a recent report of the Secretary's Commission on Nursing. The Commission found that in hospitals and nursing homes alone, there are 137,000 vacant positions for nurses.

The shortage is nationwide. We will hear testimony today about the dire needs of California, Texas, Florida and New York hospitals for health care services.

The shortage has spared neither urban nor rural hospitals, and has swept across all forms of nursing services.

It is no exaggeration to state that in New York City health care is on the brink of a disaster. The loss of 1,000 foreign trained nurses could push the city over the edge.

The dimensions of New York City's nursing shortage are frightening. Hospitals report vacancy rates of nurses ranging from 15 to 20%, or 5400 unfilled positions, at the same time that their occupancy rates exceed 95%. Nursing homes are experiencing 25% vacancy rates in registered nurses. This struggle to deal with skyrocketing caseloads and a nursing shortage presents a terrible equation for decent health care.

Faced with a growing number of patients requiring extensive and intensive care -- AIDS victims, crack addicts, and the elderly -- we cannot afford to lose beds and experienced nurses. Yet examples of desperately needed hospital beds laying fallow abound:

Lincoln Hospital in the Bronx has been unable to open a newly-constructed 28 bed, \$3.3 million AIDS ward because of the lack of nurses.

At the newest hospital in the city, Allen Pavillion of Columbia

Presbyterian, 160 out of 300 beds are unused because nurses cannot be hired.

Last year, at the Montefiore Medical Center, 60 to 80 beds a day were out of operation when overcrowding was at its worst as a result of staffing shortages. 25 patients a night were forced to sleep on gurneys in the emergency room.

In fact, a recent survey by the New York State Department of Health found that over 1,000 beds are out of service Citywide due chiefly to staffing shortages.

Losing experienced nurses at such a critical time is shattering. Yet that is precisely what will happen unless Congress acts.

As a result of the shortage, many hospitals have recruited temporary foreign trained nurses. Regulations that went into effect in 1987 capped the length of service of these nurses at 5 years. For thousands of these nurses, their time is up.

New Jersey hospitals, with 17% nurse vacancy rates, report that 10% of their registered nurses are in the U.S. on H-1 visas. Without legislation, over 1,000 of these nurses will be out of status next year.

California hospitals with 9% nurse vacancy rates and a 19% turnover rate in nurses last year, report that a significant number of H-1 nurses will lose their status next year.

Over 20% of registered nurses employed by New York City hospitals are foreign trained. With the public hospitals having lost over 1,500 registered nurses in the past 2 years, the City can hardly afford to lose a projected 1,000 foreign nurses next year.

H.R. 1507 would permit these nurses to remain in the U.S. As permanent residents. At the same time, it would build in protections for U.S. workers, and require facilities to take steps to recruit and retain U.S. nurses.

H.R. 1507 is not a panacea for the nursing shortage. But, in the short term it will stop the hemorrhaging. In the long term, it requires facilities to implement measures to make the profession more appealing and accessible to U.S. labor.

I look forward to hearing the testimony of our distinguished witnesses this morning on this urgent matter.

Mr. MORRISON. Thank you, Mr. Schumer.

The gentleman from New York, Mr. Fish. Do you have an opening statement?

Mr. FISH. Thank you, Mr. Chairman.

I just want to express my appreciation for our colleague, Mr. Ackerman, being with us this morning to spell out some of the dimensions of this problem and how we can contribute to nursing recruitment and retention. I look forward to his testimony.

Mr. MORRISON. Thank you very much.

I welcome the gentleman from New York, Congressman Gary Ackerman, to the subcommittee.

We appreciate your taking the time to draft and file the legislation and to be here to testify before us. Your written statement will be made a part of the record, and you may proceed to summarize it in any way you choose.

STATEMENT OF HON. GARY L. ACKERMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. ACKERMAN. Thank you very much, Mr. Chairman. I thank the members of this distinguished subcommittee for allowing me to testify before you this morning, and let me single out my colleague from New York, Chuck Schumer, for his great leadership in this as well as many other areas. We do think alike, and I appreciate your interest and brevity as well.

Mr. SCHUMER. If I might interrupt the gentleman, I may even start wearing a boutonniere.

Mr. ACKERMAN. That is going too far.

Mr. Chairman, since 1983 unfilled nursing positions have more than doubled, leaving more than 200,000 vacancies nationwide. Hospitals across the country have been forced to close emergency rooms, reschedule surgery, limit patient admissions, and eliminate desperately needed hospital beds due to an inability to find enough nurses to provide adequate staffing.

Exacerbating the problem, nursing schools report a 30-percent drop in enrollment, suggesting that future prospects for an adequate supply of registered nurses are bleak. This is a dangerous, life-threatening situation that is crippling the quality of our Nation's health care.

To mitigate the factors contributing to the nursing shortage crisis, I have introduced the Emergency Nurse Shortage Relief Act. This is a comprehensive package of reforms to address three different aspects of the nursing shortage: retaining practical nurses in the profession, providing incentives to encourage inactive nurses to return to practice, and promoting nursing as a professional career choice.

The only section of the bill, as I understand it, that will be considered today before your subcommittee would allow for the extension of H-1 visas for registered nurses working in nursing crisis areas if their continuing employment will not adversely affect the wages and working conditions of registered nurses in the United States.

The Secretary of Health and Human Services, under H.R. 2111, would designate areas that have a severe shortage in the number

of nurses necessary to adequately serve the health needs of the area as nursing crisis areas.

While nonimmigrant foreign nurses are not a significant proportion of the registered nurse population in this country, many urban hospitals have come to rely heavily on nurses recruited from overseas to meet staffing needs. In New York City, approximately 4,000, or 26 percent, of all hospital-employed registered nurses are foreign trained.

Under current regulations, there is a 5-year limitation on the H-1 nonimmigrant visas of foreign nurses except in rare circumstances in which a 6th year would be granted. In many nursing shortage areas where hospitals struggling to care for patients with AIDS and other severe illnesses need to rely on foreign help, visa problems can be devastating to efforts to provide needed health care services.

This became clear last year when an analysis conducted by the Greater New York Hospital Association found that at least 800 foreign nurses in the city were in their 5th year of residency and at immediate risk of deportation. The public hospital system was the most heavily affected. If the H-1 visa limitation had been enforced, the New York City Health and Hospitals Corp., which already has over 1,000 vacancies, would have immediately lost an additional 500 nurses.

Fortunately, the INS agreed to extend the H-1 visas expiring last year for an additional 6th year. However, the INS made it clear that this was intended for a short-range action and that hospitals must recruit more domestic nurses in the next few years. Well, Mr. Chairman, there just aren't enough domestic nurses to recruit. I strongly urge members of the subcommittee to support the extension of H-1 visas to prevent the deportation of foreign nurses whose services are desperately needed.

Mr. Chairman, before closing, I want to express my deep appreciation to Claire Schulman, who is the president of the New York City Borough of Queens and herself a former nurse, for her invaluable assistance in formulating the Comprehensive Emergency Nurse Shortage Relief Act. I would also like to add that there are a number of other ways in which to prevent the deportation of desperately needed foreign nurses.

I want to also state for the record, as you are well aware, that I am a cosponsor of Mr. Schumer's legislation that would permit nonresident nurses to become permanent residents and make a more stable work force available to hospitals.

The point is, modest reforms must be made in our immigration laws to ensure that health care facilities do not lose the critical services of these very dedicated foreign nurses.

Thank you very much.

Mr. MORRISON. Thank you, Mr. Ackerman.

[The prepared statement of Mr. Ackerman follows:]

PREPARED STATEMENT OF HON. GARY L. ACKERMAN, A REPRESENTATIVE
IN CONGRESS FROM THE STATE OF NEW YORK

Good Morning Mr. Chairman and distinguished members of the Judiciary Subcommittee on Immigration, Refugees, and International Law. It is a pleasure to testify this morning regarding the critical need for reforms to address the pervasive shortage of registered nurses facing our Nation.

Since 1983, unfilled nursing positions have more than doubled, leaving more than 200,000 vacancies Nationwide. Hospitals across the country have been forced to close emergency rooms, reschedule surgery, limit patient admissions and eliminate desperately needed hospital beds due to an inability to find enough nurses to provide adequate staffing.

Exacerbating the problem, nursing schools report a 30% drop in enrollment, suggesting that future prospects for an adequate supply of registered nurses are bleak. This is a dangerous, life-threatening situation that is crippling the quality of our Nation's health care.

To mitigate the factors contributing to the nursing shortage crisis, I introduced The Emergency Nurse Shortage Relief Act. This comprehensive package of reforms addresses three distinct aspects of the nursing shortage: retaining practicing nurses in the profession, providing incentives to encourage inactive nurses to return to practice and promoting nursing as a professional career choice. The only section of the bill that will be considered today would allow for the extension of H-1 visas for registered nurses working in nursing crisis areas if their continuing employment will not adversely affect the wages and working conditions of registered nurses in the United States. The Secretary of Health and Human Services would designate areas that have a severe shortage in the number of nurses necessary to adequately serve the health needs of the area, as nursing crisis areas.

While nonimmigrant foreign nurses are not a significant proportion of the registered nurse population in this country, many urban hospitals have come to rely heavily on nurses recruited from overseas to meet staffing needs. In New York City approximately 4000 or 26% of all hospital-employed registered nurses are foreign trained.

Under current regulations, there is a five year limitation on the H-1 nonimmigrant visas of foreign nurses except in rare circumstances under which a sixth year would be granted. In many nursing shortage areas, where hospitals struggling to care for patients with AIDS and other severe illnesses need to rely on foreign help, visa problems can be devastating to efforts to provide needed health care services. This became clear last year when an analysis conducted by the Greater New York Hospital Association found that at least 800 foreign nurses working in the City were in their fifth year of residency and at immediate risk of deportation. The public hospital system was the most heavily affected. If the H-1 visa limitation had been enforced, the New York City Health and Hospitals Corporation, which already had over 1000 vacancies, would have immediately lost an additional 500 nurses.

Fortunately, the INS agreed to extend H-1 visas expiring last year for an additional, sixth year. However, the INS made it clear that this was intended as a short-range action and that hospitals must recruit more domestic nurses in the next few years. Well, there aren't enough domestic nurses to recruit! I strongly urge members of the Subcommittee to support the extension of H-1 visas to prevent the deportation of foreign nurses whose services are desperately needed.

Mr. Chairman, before closing I want to express my deep appreciation to Claire Shulman, president of the New York Borough of Queens and a former nurse, for her invaluable assistance in formulating The Emergency Nurse Shortage Relief Act.

I would also like to add that there are a number of ways in which to prevent the deportation of desperately needed foreign nurses. I am a co-sponsor of Rep. Schumer's bill to permit certain non-resident nurses to become permanent residents, thus making a more stable workforce available to hospitals. The point is, modest reforms must be made in our immigration laws to ensure that health care facilities do not lose the critical services of dedicated foreign nurses.

Mr. Chairman, thank you for holding this hearing today, and inviting me to testify.

Mr. MORRISON. Your bill is essentially another stopgap measure as far as the foreign nurses, although it emphasizes efforts that are not within the jurisdiction of this committee to try to expand the supply of domestic nurses. You are also a cosponsor of Mr. Schumer's bill which takes a somewhat different approach, which is to make permanent those who are already here or who had been here for any significant period of time and then make it significantly more difficult to bring in additional temporary workers.

Those two approaches seem a little bit at odds with each other. One suggests that we are taking an approach of merely extending a temporary time frame. The other makes a step toward making permanent people who are here. When you are thinking about your bill, are you thinking of as a step toward making those who are already here permanent at some future time or not?

Mr. ACKERMAN. There is basically no incongruity between Mr. Schumer's approach and mine. As I understand it, Mr. Schumer's approach would give a more permanent status to those who are already here, and I subscribe to that approach. Anything that has to be done right now to make sure that we do not have an additional drainage of nurses certainly is the appropriate thing to do, in my mind.

But my bill addresses that as one of a number of issues and is basically a comprehensive approach to the entire nursing shortage. The only part of my bill that I believe is within the purview of the subcommittee—and certainly I would be glad to discuss the entire bill if you wish—is section 7, which would allow the extension for at least 1 additional year, and it certainly can be made longer. I have no objection to making it permanent, as Mr. Schumer's approach is.

But the basic heart of the bill—and this is one aspect of it—and the section is basically, just very quickly, besides the title, section 2 provides grants to public and nonprofit private entities to promote nursing programs. Section 3 provides grants for programs to attract inactive nurses back into the nursing professions where they have left for a variety of reasons. Section 4 is a grants program to retain practicing nurses. Section 5 provides for a loan and a loan forgiveness program in certain areas of greatest need, which would be designated by the appropriate executive authorities. Section 6 provides an income tax credit for corporations that grant scholarships for nurses; it provides for the Secretary of Health to designate these areas.

There is a provision for the Secretary of Labor to make sure that there is no adverse impact upon existing work forces where the crisis may exist. It attracts nontraditional people into the nursing profession—males, people in other fields—and makes nursing a much more attractive profession, especially in the areas that people have given for leaving nursing; it tries to take away some of those problems.

It is a basic overall approach to it, and the extension of the visa within my legislation is just one of the things necessary as we undergo the entire approach, because with all of these approaches you are not going to have all the nurses that we hoped to have and that we need to have, that we must have, on line tomorrow, and

taking away the nurses that are foreign would be disastrous while we were developing this.

Mr. MORRISON. Thank you.

Mr. Smith.

Mr. SMITH of Texas. Thank you, Mr. Chairman.

Let me just say to my colleague from New York that I very much appreciate his approach and want to compliment him for the bill.

As I understand it, you are really looking for long-term solutions, and by providing incentives and reasons for individuals to enter the nursing profession we are ultimately going to come up with the solution of alleviating the nursing crisis. I think that is exactly what we are all about, and I just think you have taken a good approach.

Gary, I want to ask you one question. Do you have any idea, adding up the grants and the various tax incentives and so on, what the cost of programs that you have suggested would be?

Mr. ACKERMAN. No, I'm afraid I don't at this time. Perhaps we can get a reading on it. But I have a very strong suspicion that the cost to our Nation in not doing it is one that we really can't tolerate.

Mr. SMITH of Texas. Fair enough.

Again, I appreciate your legislation. It looks like to me it is going straight to the heart of the problem, and I like your emphasis, I might add, on trying to recruit individuals in the United States to try to fill these spots, knowing that in the meantime we are going to need some help, perhaps from foreign nurses, but I think ultimately we need to show individuals that the nursing profession is a worthwhile profession. If we get the conditions improved and the pay up, I think we will succeed in alleviating that crisis.

Mr. ACKERMAN. I think that that is the better approach, rather than the primary approach of filling American jobs with people from overseas. We appreciate very much their willingness to work here and understand the reasons why, but I think that what we have to do as a first instance is elevate the position of nurses to where it really belongs in American society, to attract as many people from within our own society to fill them for a variety of reasons, and as needed, as is desperately needed now, to allow those who have come here from other places to fill those positions.

Mr. SMITH of Texas. Mr. Chairman, I don't have any other questions.

Mr. MORRISON. Thank you very much.

Mr. Schumer.

Mr. SCHUMER. Thank you.

I would agree with your comments, Gary, that the bills are complementary. What my bill is attempting to do is give some permanent status to the people who are here now and still allow new people to come in but gradually transitioning and telling people that we have to train American workers to be nurses.

Obviously, the present situation of just allowing H-1 visas to work hasn't done the job. Yes, there are foreign people who want to come here, and we need them, but the shortage is still as desperate as it might be, and we do need a new approach, and I think the

two are complementary. So I hope that your bill passes, and I hope that my bill passes.

Mr. MORRISON. Thank you, Mr. Schumer.

Mr. Fish, any questions?

Mr. FISH. Thank you, Mr. Chairman.

I know that just a narrow part of this H.R. 2111 is within our jurisdiction, but if I could take 1 minute, since we have Mr. Ackerman here, to go into the rest of the legislation.

Obviously, in formulating the approach that you have in this bill—and it seems very comprehensive—you had to first determine what the problem was, and I wonder if, briefly, you could tell us why it is that since 1983 the vacancies have doubled and suddenly we have this phenomenon of a 200,000 nursing shortage, a tremendous dropoff in nursing schools, whether it is since 1983 or whether it started even earlier. Could you briefly describe why you think the problem is here.

Mr. ACKERMAN. I think you will probably hear that from some of the witnesses on a more firsthand basis than I can describe, but basically it is a supply and demand situation, as everything else in the work force. As people became better educated, people were able to go from one career to another. There were certain careers that offered more money, more glamour. In the nursing profession, which was certainly more glamorous at one point in time, the pay was adequate.

Right now, the demands are much more, and the pay is less comparatively to what people can make with similar training in other fields, and people with the kinds of skills and abilities that our nurses have have been able to do much better for themselves and have been attracted, to a great measure, into other areas. The pay has not kept pace with the responsibilities. The glamour certainly has not. Many of the responsibilities of our nurses have expanded to incorporate those of orderlies. Their skills are not being employed to the extent that they can be, and many others can do many of the functions that they perform. Ergo, they sought greener pastures.

If we are to attract people back to the profession, certainly the working conditions have to be better, the hours have to be more reasonable, there have to be more people to share the responsibilities, and there have to be more people providing support services on a level other than the nurses are performing right now.

Mr. FISH. I take it you are elaborating now on the phrase "restructuring the role of nurses in the health care facilities" as part of your legislation.

Mr. ACKERMAN. Exactly.

Mr. FISH. You do go back several decades when the options for most women, in addition to motherhood, were, as professions, nursing, teaching, and as secretaries. Somebody capsulized this issue for me by saying that those who were becoming nurses years ago are now becoming doctors, so, in a way, our problem is success.

Having identified the problem, do you really think that you can change things and set up inducements so that we can get people into nursing, or back into nursing?

Mr. ACKERMAN. I think so. It is not just a matter of packaging, but I think as a matter of fact you have to provide not just the per-

ception that nursing is a glamorous career but you have to make it once again a very glamorous career.

So many people regard nurses as orderlies in the hospital, and they do perform, unfortunately, a great many of those tasks. They are just overburdened. I think if the pay was there and the responsibilities were there and the restructuring was there, you certainly could attract people.

Mr. FISH. Is there any money in here for hospitals? because every hospital in my congressional district, with one single exception, is losing money, and, of course, the hospitals in New York City are losing even more money. So, obviously, pay is an important factor here as well as status, and respect, and what-not.

Mr. ACKERMAN. Yes.

Mr. FISH. Who is going to pay for that?

Mr. ACKERMAN. This would be as part of the grants program to both public and nonpublic entities.

Mr. FISH. That goes right to the hospitals?

Mr. ACKERMAN. Yes. It could go directly to the hospital or any other entity that was interested in working in the area.

Mr. FISH. All right.

I would like to turn to this pool of inactive nurses. I had an aunt who was the head nurse of a hospital here in Washington, and I was married to a nurse, and I remember once that I got a room for a reception here by the Nurses Association, and they all wore buttons that said "40," and that was intimidating because one in 40 voters was a nurse. Well, if that is the case, there must be an awful lot of nurses who are inactive or at least not active in hospital or nursing home full time medical/surgical care. Do you have any figures on that, that pool of inactive that we could try to lure back into the profession full time?

Mr. ACKERMAN. I don't know if anybody has an actual handle on that any more. I think the one in 40, if you figure out how many years ago, it might be one in 50 now, but certainly there is, as you point out so perceptively, a very large pool of people who have gone on to raise their own families and have become inactive for that reason and could be attracted back if the attraction were large enough, and there are certainly people, who have gone into other professions because the pastures were greener and the opportunities were greater, who could be lured back if the circumstances were right, and that is what we are trying to do with the comprehensive legislation.

Mr. FISH. Well, I really commend this because, as I read this, you are going into the high schools.

Mr. ACKERMAN. Yes. There could be grants as well as the hospitals for those organizations or groups that would actually go into the schools to promote nursing and to recruit and to try to make it as exciting as it really is.

Mr. FISH. I think that is wonderful. Then you have grants to the nursing student while in the course of the education.

Mr. ACKERMAN. That is correct.

Mr. FISH. The forgiveness of that.

Mr. ACKERMAN. Yes.

Mr. FISH. Then you have these programs, I gather, basically to retrain a nurse, who is a registered nurse, who has been out of the field for a while.

Mr. ACKERMAN. The theory behind that is that it would probably be a lot less expensive to make retreads out of people who have left the profession than to start all over again, and we approach all of the areas, I think, where we can possibly find nurses, including the nontraditional.

Mr. FISH. How does this corporate scholarship tax credit work? Are you talking about the corporation giving scholarships to interested high school students as an award, or is it for their employees?

Mr. ACKERMAN. It could be either.

Mr. FISH. It could be either.

Mr. ACKERMAN. Yes, as long as any corporation would provide a scholarship for people going into this profession. We are trying to create incentives for private industry to assume part of the burden of the cost of the training so it is not picked up by the public sector entirely, and hopefully many public-minded corporations would take advantage of that, and the encouragement is here for them to do so.

Mr. FISH. Well, I really commend you.

Tell me, what is the major committee that this is before?

Mr. ACKERMAN. I believe it is before Mr. Waxman's subcommittee.

Mr. FISH. I wish you well, and I will talk to Henry about it. I think you have really given us a blueprint to work on.

Mr. ACKERMAN. Thank you very much.

Mr. FISH. Thanks a lot.

Mr. MORRISON. Thank you very much for your help and for your testimony this morning.

Mr. ACKERMAN. Thank you, Mr. Chairman, and I thank the subcommittee.

Mr. MORRISON. Our next panel will be four representatives of Cabinet departments. When I call you, please come forward and remain standing so that you may be placed under oath. James Puleo, Assistant Commissioner for Adjudications and Nationality, the Immigration and Naturalization Service; David Williams, Deputy Assistant Secretary for Employment and Training, the Department of Labor; and J. Jarrett Clinton, M.D., Director of the Bureau of Health Professions, Health Resources Services Administration, Department of Health and Human Services.

I thank you for being here. Please raise your right hand.

[Witnesses sworn.]

Thank you very much. Please be seated.

Your written statements will be incorporated in the record, and, starting with you, Mr. Puleo, if you would proceed to summarize as you see fit.

**STATEMENT OF JAMES PULEO, ASSISTANT COMMISSIONER,
ADJUDICATIONS AND NATIONALITY, IMMIGRATION AND
NATURALIZATION SERVICE**

Mr. PULEO. Thank you, Mr. Chairman.

Mr. Chairman, members of the subcommittee, I appreciate the opportunity to appear before you today to express the Department of Justice's view on H.R. 1507, a bill to amend the Immigration and Nationality Act to provide special immigrant status for certain H-1 nonimmigrant nurses and to establish conditions for the admission during a 5-year period of nurses as temporary workers.

I will comment briefly on H.R. 2111, a bill to amend the Public Health Service Act to establish programs to increase the supply of professional nurses since it would provide for extension of H-1 non-immigrant visas.

While we agree that the nursing shortage in the United States is a problem, we have a number of significant concerns with both bills. H.R. 1507 would authorize special immigrant status for a significant but unknown number of foreign nurses who have entered the United States before January 1, 1988, and are still working in H-1 status at the time this legislation is enacted.

Mr. FISH. Mr. Chairman, could I interrupt?

Mr. MORRISON. Yes.

Mr. FISH. You said "unknown number"?

Mr. PULEO. That is correct.

Mr. FISH. The Immigration and Naturalization Service does not know the number of people in the United States under certain categories of visas—

Mr. PULEO. That is correct.

Mr. FISH [continuing]. Who are actually working, and visible, and not hiding?

Mr. PULEO. Yes, sir.

Mr. FISH. Thank you.

Mr. PULEO. At the same time, this bill would reclassify nurses for the H-1 category to H-4 category and could make it much harder for health facilities to obtain nonimmigrant classification for nurses over the next 5 years by imposing a labor certification requirement.

The current problem with foreign nurses is symptomatic of two larger problems within our current immigration laws: The use of temporary worker categories to solve permanent or relatively long-term labor market shortages and the inadequacies of our permanent immigration system. The latter problem, hopefully, will soon be addressed by this Congress in a comprehensive fashion. This bill may be an opportunity to resolve the former.

This bill would remove professional nurses from the H-1 category, moving them to a separate category with a labor market test to ensure the health care industry does not become overly reliant on foreign nurses at the expense of domestic workers.

The Department is sensitive to the important needs of nursing care. We have worked with many Members of Congress, staff members, as well as individual employers, the Hospital Associations, and the American Nurses Association, congressional committees, and the Department of Health and Human Services to assist the foreign nurse situation. However, we must do so within the bounds of statute and the Immigration and Naturalization Service regulations.

In 1985, the INS imposed a 5-year limit on the temporary stay in the United States for all nonimmigrants under H-1 classification

with a possibility of a 6th year in extraordinary circumstances. Due to extensive complaints from employers and attorneys about the inconsistencies among our field offices in granting extensions of stay to aliens in the H-1 classification, the Service was compelled to adopt a uniform policy allowing a generous but specific time limit on what is regarded as a temporary for the H-1 classification. This was necessary to provide equitable treatment for employers and the H-1 aliens and to bring our offices into compliance with the statutory intent.

It is clear under this statute that the H-1 nonimmigrant must be coming to the United States for a temporary period with the intention to return to abroad and that intending immigrants cannot use the nonimmigrant classification to wait for a preference number to become available.

Our field offices had adopted varying rules as to what temporary, many choosing 3 years, some allowing much longer periods of time, before finding that the aliens' intent to remain in the United States was no longer temporary.

The 5/6-year limit on a temporary stay under the H-1 classification was implemented after a lengthy and open process of consultation with the Department of State, and attorney and employer groups, congressional representatives, and directors of our field offices. The February 26, 1987, rulemaking merely codified this policy into regulation.

Where health care facilities experience a problem with the 5/6-year limit, it is because they employ a larger number of foreign nurses who cannot adjust to permanent resident status during their 5/6-year period in the United States.

Data from a labor market study conducted for the Service indicates that approximately 75 percent of foreign nurses in the United States are from the Philippines, where the wait for a preference number may exceed 10 years under the third and sixth preferences. The requirements that H-1 nonimmigrants, including foreign nurses, leave the United States after a 5/6-year period of stay if they cannot adjust to permanent resident status during the 5 years seems to have affected health care facilities in early 1988.

The health care industry, supported by nursing organizations, convinced the Department of Justice and Congress that there is a nursing shortage. Some health care experts have indicated that the shortage can be expected to worsen and extend through the year 2000.

During the past 2 years, the INS and Congress have taken steps to give the health care facilities short-term relief with the understanding that they would make good faith efforts to recruit and retain U.S. nurses and reduce their reliance on foreign nurses. The INS granted a blanket 6-year extension to nurses whose applications were filed between January 1 and December 31, 1988.

Public Law 100-658, passed by Congress in November 1988, provided for an extension of the H-1 status of certain nurses through December 31, 1989. This law extends the stay and reinstates to legal status those nurses in the H-1 status for 5 years whose status will expire before December 31, 1989, and those nurses whose status expired after January 1, 1987, but who continue to work as nurses.

H.R. 1507 is intended to be a long-term solution which will allow experienced nurses already in the United States to become permanent residents and, at the same time, reduce reliance of health care facilities on foreign nurses over the next 5 years.

Data from various sources indicate that 20,000 to 25,000 foreign nurses have entered the United States since 1980. INS estimates from this data that more than half of these nurses are still in H-1 status and would benefit from the special immigrant provision. INS also believes that a significant number of foreign nurses are currently out of H-1 status.

H.R. 1507 authorizes special immigrant status for foreign nurses who enter the United States as H-1 nonimmigrants before January 1, 1988, and are employed as registered nurses, are maintaining H-1 nonimmigrant status on the date of enactment of this legislation, and have received a labor certification under section 212(a)(14) of the act before special immigrant status is granted.

Effectively, it would give special immigrant status to nurses who have worked in the United States for as little as 2 years and could deny it to nurses who may have worked 5 or more years, as they may not be in legal status by the time this legislation is enacted. In addition, there is no requirement for those granted special immigrant status to remain in the nursing profession for a minimum period of time.

The Department believes that the bill is too generous in its requirements for special immigrant status in terms of the length of time a foreign nurse must have already worked in the United States and the lack of any requirement for the nurse to continue working in the nursing field for a certain period of time after obtaining special immigrant status.

The Department believes that the foreign nurse should have had, and must continue to have, a strong commitment to nursing in the United States. We recommend that the bill require a nurse to have worked in the United States in H-1 status for at least 5 years, to be permanently licensed in a State or territory of the United States, and to make a 2- or 3-year commitment to continue working in the nursing field after obtaining special immigrant status.

The proposed changes in requirements for classification and admission of foreign nurses as nonimmigrants make the process very time-consuming because of the requirement for individual labor certification. The changes will require more paperwork and time than the current process for permanent immigration of nurses. In addition, the language is so specific that the Department of Labor and INS would have little flexibility in developing appropriate regulations to implement the statutory amendment.

The provisions are a mixture of requirements under the Department of Labor's permanent labor certification process and Immigration's requirement for the H-1 nonimmigrant classification. As a result, some of the provisions and terminology are technically inappropriate in terms of the two agencies' functions and policies in other immigration categories.

The Department believes that a statutory amendment should not address the procedures which are ordinarily set forth in regulations. Congress' intent and guidance on implementing regulations are expressed in committee reports and in other legislative history

as are closely followed by agencies in developing regulations to implement a statutory implementation. It is simpler and more effective to change regulations with a procedure that does not work effectively or conditions change the amendment—amend the statute.

H.R. 1507 removes registered nurses from consideration under H-1 nonimmigrant status and establishes a new H-4 nonimmigrant category to accommodate special immigrant classifications.

H.R. 1507 prescribes in detail the requirement which a foreign nurse and the employing facility must meet in order for a foreign nurse to qualify under H-4 classification.

With respect to the H-4 classification, we note that it has over the years been accorded to spouses and minor children of H-1, H-2, and H-3 nonimmigrants. Designating foreign nurses H-4 and redesignating the spouse and children of beneficiaries under all H classifications as H-5's would create confusion for the public and problems for the Department of State and INS. The Department therefore recommends that consideration be given to dividing the H-1 category into paragraphs similar to H-2 category.

There are now more than 5,000 H-1 nurses admitted annually to supplement the work force of U.S. nurses and foreign nurses already submitted. This figure would drop dramatically under the H-4 category by virtue of the processing time.

The only provision contained in H.R. 2111 of interest to the Department is section 7, which provides for an extension of the H-1 visa through a 6th year of nurses who have worked for 5 years in the nursing crisis areas. In practice, we believe that this section would require a nurse seeking a 6th-year extension to obtain a statement from HHS that he or she has been working in a nursing shortage area, to obtain an individual labor certification from the Department of Labor, and to file a timely application for extension with INS.

The Department recommends, instead of section 7, that Congress endorse the 5-year limit on temporary stay under H-1 classification with a 6th year in extraordinary circumstances, as set forth in INS regulation. We look forward to working further with the committee on this crucial issue.

Thank you, Mr. Chairman.

Mr. MORRISON. Thank you.

[The prepared statement of Mr. Puleo follows:]

PREPARED STATEMENT OF JAMES PULEO, ASSISTANT COMMISSIONER, ADJUDICATIONS
AND NATIONALITY, IMMIGRATION AND NATURALIZATION SERVICE

Mr. Chairman and members of the Subcommittee:

I appreciate the opportunity to appear before you today to express the Department of Justice's views on H.R. 1507, a bill to amend the Immigration and Nationality Act to provide for special immigrant status for certain H-1 nonimmigrant nurses and to establish conditions for the admission, during a five year period, of nurses as temporary workers. I will comment briefly on H.R. 2111, a bill to amend the Public Health Service Act to establish programs to increase the supply of professional nurses, since it would provide for extension of H-1 nonimmigrant visas. While we agree that the nursing shortage in the United States is a problem, we have a number of significant concerns with both bills.

H.R. 1507.

H.R. 1507 would authorize special immigrant status for a significant, but unknown number of foreign nurses who entered the United States before January 1, 1988 and are still working in H-1 status at the time this legislation is enacted. At the same time, this bill would reclassify nurses from the H-1 category to the H-4 category and could make it much harder for health facilities to obtain nonimmigrant classification for foreign nurses over the next five years by imposing a labor certification requirement.

The current problem with foreign nurses is symptomatic of two larger problems within our current immigration laws: the use of temporary worker categories to solve permanent or relatively long-term labor market shortages and the inadequacy of our permanent immigration system. The latter problem,

hopefully, will soon be addressed by this Congress in a comprehensive fashion. This bill may be an opportunity to resolve the former.

This bill would remove professional nurses from the H-1 category, moving them to a separate category with a labor market test to insure the health care industry does not become overly reliant on foreign nurses at the expense of domestic workers.

The Department is sensitive to the important needs in nursing care. We have worked with many Members of Congress, staff members, as well as with individual employers, hospital associations, the American Nurses Association, Congressional committees, and the Department of Health and Human Services (HHS) to assist with the foreign nurse situation. However, we must do so within the bounds of the statute and Immigration and Naturalization Service (INS) regulations. In September 1985, the INS imposed a five year limit on a temporary stay in the United States for all nonimmigrants under the H-1 classification, with a possibility of a sixth year in extraordinary circumstances.

Due to extensive complaints from employers and attorneys about the inconsistencies among our field offices in granting extensions of stay to aliens in the H-1 classification, the Service was compelled to adopt a uniform policy allowing a generous but specific time limit on what is regarded as temporary for the H-1 classification. This was necessary to provide equitable treatment for employers and H-1 aliens and to bring our offices into compliance with statutory intent. It is clear under the statute that H-1 nonimmigrants must be

coming to the United States for a temporary period with the intention to return abroad and that intending immigrants cannot use the nonimmigrant classifications to wait for a preference number to become available. Our field offices had adopted varying rules as to what is "temporary," many choosing three years, some allowing much longer periods of time before finding that the alien's intent to remain in the United States was no longer temporary.

The five/six year limit on a temporary stay under the H-1 classification was implemented after a lengthy and open process of consultation with the Department of State, attorney and employer groups, Congressional representatives, and directors of our field offices. The February 26, 1987 rulemaking merely codified this policy into regulations.

Where health care facilities are experiencing a problem with the five/six year limit, it is because they employ a large number of foreign nurses who cannot adjust to permanent resident status during their five/six year period of stay. Data from a labor market study conducted for the Service indicated that approximately 75 percent of the foreign nurses in the United States are from the Philippines where the wait for a preference number may exceed 10 years under the third and sixth preferences.

The requirements that H-1 nonimmigrants, including foreign nurses, leave the United States after a five or six year period of stay if they have not adjusted to permanent resident status during the five years seems to have affected health facilities in early 1988. The health care industry, supported by nursing organizations, convinced the Department of Justice and Congress that there is a nursing shortage. Some health care experts have also indicated that

the shortage can be expected to worsen and extend through the year 2000.

During the past two years the INS and Congress have taken steps to give health care facilities short-term relief with the understanding that they would make good faith efforts to recruit and retain United States nurses and reduce their reliance on foreign nurses. The INS granted a blanket sixth year extension to nurses whose applications were filed between January 1 and December 31, 1988. Public Law 100-658, passed by Congress in November 1988, provided for extension of the H-1 status of certain nurses through December 31, 1989. This law extends the stay, or reinstates to legal status, those nurses in H-1 status for five years whose status will expire before December 31, 1989, and those nurses whose status expired after January 1, 1987 but who continued to work as nurses.

H.R. 1507 is intended to be a long-term solution which will allow experienced foreign nurses already in the United States to become permanent residents, and at the same time, reduce reliance of health care facilities on foreign nurses over the next five years. Data from various sources indicate that 20,000 to 25,000 foreign nurses have entered the United States since 1980. INS estimates from its data that more than half of these nurses are still in H-1 status and would benefit from the special immigrant provision. INS also believes that a significant number of foreign nurses are currently out of H-1 status.

Special Immigrant Status for Certain H-1 Nurses

H.R. 1507 authorizes special immigrant status for foreign nurses who entered the United States as H-1 nonimmigrants before January 1, 1988, are employed as registered nurses, are maintaining H-1 nonimmigrant status on the

date of enactment of this legislation, and have received a labor certification under section 212(a) (14) of the Act before special immigrant status is granted.

Effectively, it would give special immigrant status to nurses who have worked in the United States for as little as two years and could deny it to nurses who may have worked five or more years, as they may not be in legal status by the time this legislation is enacted. In addition, there is no requirement for those granted special immigrant status to remain in the nursing profession for a minimum period of time.

The Department believes that the bill is too generous in its requirements for special immigrant status in terms of the length of time a foreign nurse must have already worked in the United States, and the lack of any requirement for the nurse to continue working in the nursing field for a certain period of time after obtaining special immigrant status.

The Department believes that the foreign nurse should have had and must continue to have a strong commitment to nursing in the United States. We recommend that the bill require a nurse to have worked in the United States in H-1 status for at least five years, to be permanently licensed in a state or territory of the United States; and to make a two or three year commitment to continue working in the nursing field after obtaining special immigrant status.

Requirements for Admission of Nonimmigrant Nurses during 5-Year Period

The proposed changes in requirements for classification and admission of foreign nurses as nonimmigrants will make the process very time-consuming because

of the requirement for individual labor certification. The changes would require more paperwork and time than the current process for permanent immigration of nurses. In addition, the language is so specific that the Department of Labor (DOL) and INS would have little flexibility in developing appropriate regulations to implement this statutory amendment. The provisions are a mixture of requirements under DOL's permanent labor certification process and INS' requirements for H-1 nonimmigrant classification. As a result, some of the provisions and terminology are technically inappropriate in terms of the two agencies' functions and policies in other immigration categories.

The Department believes that a statutory amendment should not address procedures which are ordinarily set forth in regulations. Congress' intent and guidance on implementing regulations as expressed in Committee Reports and other legislative history are closely followed by agencies in developing regulations to implement a statutory amendment. It is simpler and more efficient to change a regulation when a procedure does not work effectively or conditions change than to amend the statute.

New H-4 category.

H.R. 1507 removes registered nurses from consideration under the H-1 nonimmigrant classification and establishes a new H-4 nonimmigrant category to accommodate new special requirements for the classification and admission of nonimmigrant nurses over the next five year period following enactment of this legislation.

H.R. 1507 prescribes in detail the requirements which a foreign nurse and

the employing facility must meet in order for a foreign nurse to qualify for H-4 classification. It requires a Department of Labor certification of the facility's eligibility, such certification being limited to one year. The Department defers to the Department of Labor on the appropriateness of this proposed new role.

With respect to the H-4 classification, we note that it has, over the years, been accorded to spouses and minor children of H-1, H-2, and H-3 nonimmigrants. Designation of foreign nurses as H-4s and redesignating the spouses and children of beneficiaries under all the H classifications as H-5s would create confusion for the public and problems for the Department of State and INS with past and future records of data on visas issued and types of admissions to the United States. The Department, therefore, recommends that consideration be given to dividing the H-1 category into paragraphs similar to the H-2 category.

There are now more than 5,000 H-1 nurses admitted to the United States annually to supplement the work force of U.S. nurses and foreign nurses already admitted. This figure will drop dramatically under the H-4 category by virtue of the processing time required. Considering reports about nursing shortages, and the fact that such shortages appear to have multi-faceted causes, including nursing salaries, working environment and opportunities for professional advancement, the Department doubts that the new initiatives to recruit, train, and retain U.S. workers and the conversion of certain H-1 nonimmigrants to special immigrant status will significantly lessen nursing shortages over the next five years. This will cause some health care facilities to continue to need significant numbers of nonimmigrant nurses.

H.R. 2111

The only provision contained within H.R. 2111 of interest to the Department is section 7 which provides for extension of H-1 visas to a sixth year for nurses who have worked for five years in a nursing crisis area and have obtained a labor certification from the Department of Labor (DOL).

This bill does not preclude nurses who have not worked in a nursing shortage area from obtaining sixth year extensions under extraordinary circumstances like all other H-1 professionals. If this is the case, nurses who worked in a nursing shortage area will have to go through a much more time-consuming and burdensome process to obtain an extension.

In practice, we believe that section 7 would require a nurse seeking a sixth year extension to 1) obtain a statement from HHS that he or she has been working in a nursing shortage area, 2) obtain an individual labor certification from DOL, and 3) file a timely application for extension with INS. A nurse and the employer would have to begin such a process six to eight months before the fifth year expired.

The Department recommends instead of section 7 that Congress endorse the five year limit on a temporary stay under the H-1 classification, with a sixth year in extraordinary circumstances, as set out in INS regulations.

We look forward to working further with the Committee on this crucial issue.

Mr. MORRISON. Mr. Williams. And if you could try to summarize your statement within 5 minutes, we would appreciate it.

STATEMENT OF DAVID O. WILLIAMS, DEPUTY ASSISTANT SECRETARY, EMPLOYMENT AND TRAINING ADMINISTRATION, U.S. DEPARTMENT OF LABOR, ACCOMPANIED BY THOMAS BRUENING, CHIEF, DIVISION OF FOREIGN LABOR CERTIFICATIONS, U.S. EMPLOYMENT SERVICE

Mr. WILLIAMS. Yes, sir. Thank you, Mr. Chairman.

Mr. Chairman and members of the committee, I am pleased to have the opportunity to discuss the Department of Labor's views on H.R. 1507 and H.R. 2111. Both bills address the Nation's current concern with the shortage of registered nurses in major urban areas and in rural communities.

First, we would agree that there are current shortages of nurses in some areas and that they may be expected to continue for some time. Shortages are being reported by hospitals and other health care facilities. Reports submitted to the former Health and Human Services Secretary Bowen by the Nursing Commission indicate a shortage of registered nurses is widespread and is the result of an increase in demand rather than supply. It has been previously mentioned that estimates are current shortages of 137,000 nurses. The Bureau of Labor Statistics has also indicated the future supply will not be adequate to meet demand through the year 2000 with an aging and growing population.

Second, we would agree that the utilization of alien nurses may contribute to alleviating the nursing shortage in the short run. However, we further believe that such usage should not affect efforts to develop an adequate supply of nurses among U.S. workers, as previously mentioned in testimony, greater utilization of those interested in health careers, incentives to those and to the facilities hiring them. Particularly mentioned in previous testimony were the need to attract more male applicants, minorities who are not now involved, and to those seeking a second career.

We know that the limitations of foreign nursing supplies are limited. They are limited in terms of numbers, present restrictions on immigration, language barriers, restrictions by the countries of origin, State licensing requirements, and, as previously mentioned, those countries of origin which have, themselves, serious reliance and health problems which require nursing assistance.

To this end, we believe H.R. 1507 would remove certain registered nurses from the H-1 status and grant them special immigration status. We favor that, retaining those nurses who are presently in the U.S. labor market and not adding to the shortage. We believe the bill would significantly expand the Department's certification duties in connection with the new proposed H-4 nonimmigrant visa.

H.R. 2111 would amend the Public Health Service Act to establish a number of programs that are designed to increase the supply of professional nurses in the United States. Section 7 of the bill directly relates to the Department's Foreign Labor Certification Program. It extends the time period temporary H-1 nurses are eligible to remain in the United States at least 1 additional year.

The immigrant nurses must, however, meet certain conditions. They must be employed in the nursing crisis area as designated by the Secretary of HHS and, upon completion of the 5th year, receive a labor certification from the Department certifying that continued employment of the immigrant will not adversely affect wages and working conditions of registered nurses in the United States.

While recognizing these bills are intended to alleviate the nursing shortage, the Department has a number of problems with both bills. The major problem involves the extent to which the bills actually would address both current and projected nursing shortages. In brief, 1507 would make it possible for up to—and this is an estimate—up to 16,000 foreign nurses currently working on H-1 visas to become permanent legal residents immediately. At the same time, it would make the process of bringing in additional H-1 nurses considerably more difficult.

In view of the fact that there are current nursing shortages in some areas and that such shortages may continue, we question whether this combination of possibly offsetting measures is appropriate. There is some evidence of H-1's are currently concentrated in a few major metropolitan areas so that this legalization would provide relief to those areas but not to other areas where there may be shortages.

While the Department wants to be sure that the jobs, wages, and working conditions of U.S. workers will not be adversely affected by the use of foreign workers and, for this reason, supports the labor certification process, we see no need for imposing the labor certification process in a situation where we believe there are at this time such clear cut and well documented shortages. In this regard, the Department has included nurses in schedule A under the Permanent Alien Certification Program since 1981.

A second concern is whether it is sound immigration policy to provide special legalization programs outside of the regular numbers under the Immigration and Nationality Act on an occupation-by-occupation basis. While such an approach was accepted within the unique context of the Immigration Reform and Control Act of 1986 for agricultural workers, H.R. 1507 would establish a post-IRCA precedent.

In view of the projected shortages in numerous occupations by the year 2000, H.R. 1507 would create pressure for similar treatment for those, we believe, in other occupations unless overall numbers under the Immigration and Naturalization Act for labor-market-based immigration were raised.

Another concern involves the precedent in both H.R. 1507 and H.R. 2111 of requiring labor certification for temporary employment in professional type jobs. Such occupations under the H-1 category have traditionally been exempt from labor certification.

A final set of concerns involves the administrative aspects of the labor certification process called for in H.R. 1507. In general, this process, we believe, would be more time consuming, more complex, and more cumbersome than the current alien labor certification process. It may well add to the current process.

Among other things, the Department would be required to certify that a substantial disruption of health care services would occur at a facility without the service of the alien and the facility, it,

too—the facility—is taking significant steps in a timely fashion to recruit and retain R.N.'s who are U.S. workers. It would be extremely difficult to set objective criteria with respect to these requirements to be applied uniformly to such a diverse universe of employing facilities.

Another difficulty in implementing the proposed H-4 program is the requirement that the Department identify geographical areas that have a critical shortage of nurses. The Department does not generate this kind of detailed supply and demand data at this time.

In summary, the Department can give qualified support to legalizing H-1's already here on the basis this appears to be needed to provide immediate relief for certain health care institutions, although we have some reservations about the precedent. However, we question whether the administrative mechanisms proposed are responsive to the current and projected nursing shortages. We also have serious concerns about the administrative feasibility of the certification process called for in H.R. 1507.

We look forward to working with the committee on these matters. Thank you for the opportunity to comment on these bills. We will be pleased to respond to any questions you may have, Mr. Chairman.

Mr. MORRISON. Thank you very much.

[The prepared statement of Mr. Williams follows:]

STATEMENT OF DAVID O. WILLIAMS
DEPUTY ASSISTANT SECRETARY
EMPLOYMENT AND TRAINING ADMINISTRATION
U.S. DEPARTMENT OF LABOR
SUBCOMMITTEE ON IMMIGRATION, REFUGEES AND
INTERNATIONAL LAW
COMMITTEE ON THE JUDICIARY
UNITED STATES HOUSE OF REPRESENTATIVES

May 31, 1989

Mr. Chairman, Members of the Subcommittee: I am pleased to have this opportunity to discuss the Department of Labor's views on H.R. 1507 entitled, "Immigration Nursing Relief Act of 1989" and on H.R. 2111 entitled, "Emergency Nurse Shortage Relief Act of 1989." Both bills address the nation's current concern with the shortage of registered nurses (RNs) in major metropolitan areas and in rural communities.

First, we agree that there are current shortages of nurses in some areas and that these shortages may continue.

Currently, shortages of RNs are being reported by hospitals and other employing facilities throughout the United States (U.S.). The report submitted to former Secretary of Health and Human Services, Otis R. Bowen, by the Commission on Nursing reports that the "shortage of RNs is real, widespread, and of significant magnitude . . . it is primarily the result of an increase in demand as opposed to a contraction of supply." As for the future, the Commission has stated that "the future supply of RNs will not be adequate to meet anticipated demand."

The Bureau of Labor Statistics also reports that the demand for registered nurses is expected to rise much faster than the average for all occupations through the year 2000 in response to the health care needs of a growing and aging population.

Second, we agree that the utilization of alien nurses may contribute to alleviating the nursing shortage. However, we believe such usage should not affect efforts to develop an adequate supply of nurses among U.S. workers. We also tend to agree with the Commission that the potential use of foreign nurses is limited for other reasons. As stated by the Commission:

Foreign nurses cannot be relied upon as a source for significantly increasing the overall domestic supply of RNs. Expansion of the use of foreign nurses is problematic because of a number of factors: the limited supply of qualified nurses in source countries; U.S. immigration and foreign emigration restrictions; language barriers which potentially affect perceptions of service quality; and state licensure requirements. Beyond these factors, the propriety of drawing nurses from countries which may themselves have serious health care needs is of concern, as is the desirability of relying on foreign sources to solve domestic shortages.

It is within this context that we view the two bills being considered by this Committee. H.R. 1507 would remove certain RNs from the H-1 nonimmigrant category and grant them special immigration status if they meet the prescribed conditions in the bill, thus retaining in the U.S. RNs who have already been absorbed in the labor market, and thereby not adding to the

shortage crisis in certain States. The bill also would significantly expand the Department's certification duties in connection with a new H-4 nonimmigrant visa category to insure that employing facilities meet certain conditions designed to protect the wages and working conditions of U.S. workers. Furthermore, the bill would require the Department to generate data on RN shortages by metropolitan statistical areas.

H.R. 2111 would amend the Public Health Service Act to establish a number of programs that are designed to increase the supply of professional nurses in the U.S. Section 7 of the bill directly relates to the Department's foreign labor certification program. It extends the time period temporary H-1 nurses are eligible to remain in the U.S. at least one additional year. The immigrant nurses must however meet certain conditions: they must be employed in a nursing crisis area (as designated by the Secretary of HHS) and upon the completion of the fifth year receive a labor certification from the Department certifying that continued employment of the immigrant will not adversely affect the wages and working conditions of RNs in the U.S.

While recognizing that these bills are intended to alleviate the nursing shortage, and agreeing that they would have some positive effect in that regard, the Department nevertheless has a number of problems with both bills. The major problem involves the extent to which these bills actually would address both current

and projected nursing shortages. In brief, H.R. 1507 would make it possible for up to 16,000 foreign nurses currently working on H-1 visas to become permanent legal residents immediately. At the same time, it would make the process of bringing in additional H-1 nurses considerably more difficult. In view of the fact that there are current nursing shortages in some areas and that such shortages may continue, we question whether this combination of possibly offsetting measures is appropriate.

In addition, there is some evidence that H-1s are currently concentrated in a few major metropolitan areas, so that this legalization would provide relief to those areas but not to other areas where there may be shortages. H.R. 2111 would extend current H-1s for a sixth year, but would impose a labor certification requirement by the Department of Labor in order to secure approval for that sixth year.

While the Department wants to be sure that the jobs, wages and working conditions of U.S. workers will not be adversely affected by the use of foreign workers -- and for this reason supports the labor certification process -- we see no need for imposing the labor certification process in a situation where we believe there are at this time such clear-cut and well documented shortages. In this regard the Department has included nurses in Schedule A under the permanent alien labor certification program since 1981, as an occupation which is considered precertified because it is

an occupation in short supply. This position on labor certification applies to both the proposed new H-4 category in H.R. 1507 and the certification for a sixth year under H.R. 2111. We therefore oppose the requirement to impose the labor certification process on nurses contained in these two bills.

A second concern is whether it is sound immigration policy to provide special legalization programs outside of the regular numbers under the Immigration and Nationality Act (INA) on an occupation-by-occupation basis. While such an approach was accepted within the unique context of the Immigration Reform and Control Act (IRCA) of 1986 for agricultural workers, H.R. 1507 would establish a post-IRCA precedent. In view of the projected shortages in numerous occupations by the year 2000, H.R. 1507 would create pressures for similar treatment for those occupations, unless overall numbers under the INA for labor-market-based immigration were raised.

Another concern involves the precedent in both H.R. 1507 and H.R. 2111 of requiring labor certification for temporary employment in professional-type jobs. Such occupations under the H-1 category have traditionally been exempt from labor certification. If labor certification were required for nurses, the question could reasonably be raised as to why not for other H-1 occupations, particularly when such clear-cut shortages do not appear to exist

in these other occupations. This is an issue the Department is continuing to explore.

A final set of concerns involves the administrative aspects of the labor certification process called for in H.R. 1507. In general, this process would be more time-consuming, more complex, and more cumbersome than the current alien labor certification process. In effect, it would add to the current process (which basically tests for U.S. worker availability against a specific job) a need to certify various activities within an employing facility.

Among other things, the Department would be required to certify that:

1. A substantial disruption of health care services would occur at the facility without the service of the alien; and
2. The facility is taking significant steps in a timely fashion to recruit and retain RNs who are U.S. workers.

It would be extremely difficult to set objective criteria with respect to these requirements to be applied uniformly to such a diverse universe of employing facilities. It will also be very difficult to quantify or set thresholds for other qualifying conditions such as "adequate" support services and "reasonable" opportunities for "meaningful" salary advancement. We therefore oppose these requirements.

Another difficulty in implementing the proposed H-4 program is the requirement that the Department identify geographical areas that have a critical shortage of nurses. The Department does not generate this kind of detailed supply and demand data and questions the advisability of imposing this burdensome requirement.

In summary, the Department can give qualified support to legalizing H-1s already here on the basis that this appears to be needed to provide immediate relief for certain health care institutions, although we have reservations about the precedent this sets. However, we seriously question whether the mechanisms proposed by H.R. 1507 or H.R. 2111 are responsive to the current and projected nursing shortages. We also have serious concerns about the administrative feasibility of the certification process called for in H.R. 1507. The issue of how best to address the long-term nursing situation in this country will require further study. Reforms to the over-all immigration system may help in addressing this problem.

Thank you for the opportunity to comment on these bills. I will be pleased to respond to any questions you may have.

Mr. MORRISON. Dr. Clinton, we thank you for being here. We noted some reluctance of HHS to send an official spokesman today. We note that we don't have written testimony from you. We invite you to make whatever statement you wish, but we do think it is important that you be here as a representative of the Department which is charged for oversight of a very large portion of the health care policy and health care financing of the United States and believe we may have questions that are important from the perspective of your Department.

So I don't know if you have a statement. If so, please make it within the 5-minute limit, and we will then proceed with questions.

STATEMENT OF J. JARRETT CLINTON, M.D., DIRECTOR, BUREAU OF HEALTH PROFESSIONS, HEALTH RESOURCES SERVICES ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. CLINTON. I'll just summarize very briefly, Mr. Chairman. I am pleased to be able to participate in this discussion this morning.

In essence, we have looked at the nursing crisis for the last 18 months. I think there is no reluctance on the Department's part to acknowledge that there's widespread shortages of nurses. It is not the same epidemic, if you will, in every city, and it varies, depending on the skills of hospital administrators, wage rates, and a variety of things that have already been noted.

We worked with the Nursing Commission extensively, providing information, our viewpoints; our Division of Nursing Director was an ex officio member of that group; we have responded from our agency to the Department of Health and Human Services with regard to our views on how we would implement our roles that are recommended in the nursing report, and that is under consideration by Dr. Sullivan, the Secretary of the Department, at this time.

I would hope—we would hope that any effort along the lines of these bills would carefully consider the anticipated benefits at the expected costs, the costs of not only this Nation but the nations that will provide the nurses—namely, the Philippines and others that are the major exporters of nursing—and then make a determination whether those energies are best directed in that direction or perhaps to some of the other issues that Congressman Ackerman and others in the nursing arena have addressed.

It is unclear to us how much benefit will be gained by the various immigration proposals that are before you, but we defer the legalities and the issues of immigration to the Department of Labor and the Department of Justice. I'd like to see more specific numbers before we could comment upon its contribution to resolving the current issue.

Let me stop at that, and I'll respond to your questions.

Mr. MORRISON. Thank you very much.

First, Dr. Puleo and Mr. Williams, it seems to me a good place to start is Dr. Clinton's question about numbers. I shared my colleague Mr. Fish's reaction to the unknown number of H-1 nurses which was in your testimony, and, Mr. Williams, you spoke of

16,000 individuals whom you projected would be legalized under Mr. Schumer's bill.

First, could you explain where you got your 16,000, and, Mr. Puleo, could you explain why it is that INS doesn't know how many H-1 nurses there are?

Mr. WILLIAMS. Mr. Chairman, I mentioned a figure of an estimate of up to 16,000 in my testimony from our own staff. Mr. Bruening of our staff is responsible for the immigration program. He is reviewing these numbers on a regular basis. I would defer to him in terms of the source of the actual estimates. I have seen estimates from prior times of between 11,000 and 16,000 in this area of those that would be made permanent.

Mr. MORRISON. If you are going to testify, I would like to put you under oath.

[Mr. Bruening sworn.]

Would you please state your name and position for the record.

Mr. BRUENING. My name is Thomas M. Bruening. I'm the Chief of the Division of Foreign Labor Certifications in the U.S. Employment Service of the Department of Labor.

With respect to the estimate of 16,000, that is a rough estimate based simply on numbers of admissions under H-1 for nurses which we did obtain from staff in the Immigration Service.

Now there is some question as to specifically how the criteria in H.R. 1507 would be applied, but we think we are in the ball park. In other words, there's been 2,000 to 3,000 H-1's admitted each year in recent years, and in the past year I think it has gone in the neighborhood of 5,000 to 7,000, based on the best information we could get.

So totaling those up and, again, looking at the criteria in the bill as the cutoff date, it would seem to us it is in that neighborhood, maybe between 12,000 and 20,000.

Mr. MORRISON. Mr. Puleo, you supplied at the committee's request earlier in the year a series of tables setting forth numbers of nurses admitted under H-1. Are you familiar with the tables I'm speaking of?

Mr. PULEO. Yes, I am. No, that's the number of admissions into the United States who were nurses. There may be multiple entries. That's why in my testimony I gave an estimate of 20,000 to 25,000 who have entered the United States from 1980 to 1987, I believe, and it is because that is the only data base we currently have that tracks by type of employment.

Unfortunately, we never had the resources to develop a data base within Adjudications. However, Congress was very generous in giving us the reimbursement account this year, for which I as the program manager am extremely grateful. We are developing a data base now that, in the future, will give you any answer we can under the categories, but to date we don't have the data base, other than the Nonimmigration Information System which generated those tables you have before you.

Mr. MORRISON. We have various numbers. The tables are headed "All years for" for instance, "1988." What does that mean?

Mr. PULEO. That is the time—the number of times a person entered the United States in that category. For example, there may be an H-1 nurse who has entered two or three times. There would

be two or three counts of one individual, and that is why we had to give you an estimate. That is the only data base we have now.

Mr. MORRISON. And on these tables, which, without objection, will be made part of the record, you have a table for a period, 1985 through 1988, and you have a total of 17,000 and a few. That would mean that was the total number of H-1 nurses who entered the United States no matter whether—that might be multiple entries, but it was no more than 17,000 individuals; that would be the absolute lowest it could be, and it is probably lower than that because there are multiple entries.

Mr. PULEO. Exactly. It would be less than that. That would be the high figure. That is why I would estimate it is somewhere between 10,000 and 15,000 that would be affected by this bill.

[The tables follow:]



U.S. Department of Justice

Immigration and Naturalization Service

CO 703.702

425 Eye Street N.W.
Washington, D.C. 20536

12 MAY 1989

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IMMIGRATION

Honorable Bruce A. Morrison
Chairman, House Subcommittee on Immigration,
Refugees, and International Law
Room 2137
Rayburn House Office Building
Washington, D.C. 20515

Dear Mr. Chairman:

At our meeting on Monday, May 3, 1989 you requested copies of any data which the Service has that might be helpful in determining the number of H-1 nurses in the United States.

It is difficult to draw any accurate conclusions about the number of H-1 nurses in the United States from the various sources of data. Perhaps the most reliable base of information is the number of certificates issued to foreign nurses after they have passed the Commission on Graduates of Foreign Nursing Schools (CGFNS) examination. The CGFNS has reported that it issued 25,466 certificates from 1979 to 1987. Foreign nurses must pass the CGFNS or be permanently licensed in the state of intended employment. For initial admission, almost every foreign nurse provides evidence in the form of a CGFNS certificate.

We are attaching other sources of data as follows:

- Annual and cumulative tables from 1985 to 1988 on nurses who arrived in a given year and are still in H-1 status.
- Information and data compiled on Filipino nurses.
- Data supplied by hospital associations.
- Data collected under P.L. 100-658 at Regional Service Centers.

I hope this information is helpful to you.

Sincerely,

James A. Puleo
Assistant Commissioner,
Adjudications

Attachment

Data from INS Nonimmigrant Information System (NIIS) on nurses who arrive in the fiscal year and are still in status at the end of that year. Cumulative table shows nurses who arrived between 1985 and 1988 and are still in the U.S. as H-1 nonimmigrants. These figures have been adjusted upwards by 40 percent to account for the frequency that the occupation is unreported in the system.

TABLE FIVE: H-1 NURSES BY COUNTRY OF CITIZENSHIP AND STATE OF INTENDED RESIDENCE
CONTROLLED FOR UNDERCOUNT
FISCAL YEAR 1986

ALL YEARS FOR 1986

COUNTRY OF CITIZENSHIP	ALL STATES	CALI- FORNIA	CON- NECTICUT	FLORIDA	HAWAII	MARYLAND	MASS- ACHU- SETTS	MICHIGAN	NEW JERSEY	NEW YORK	TEXAS	OTHER
Total.....	9,191	775	294	551	98	94	526	161	2,086	3,344	628	583
EUROPE.....	1,195	280	10	124	14	4	179	4	82	328	39	128
IRELAND.....	538	85	4	102	12	-	57	2	14	102	27	73
UNITED KINGDOM.....	589	214	4	102	-	-	57	2	14	102	27	73
OTHER EUROPE.....	63	12	2	6	2	4	-	-	6	22	4	6
ASIA.....	6,404	271	192	226	2	51	269	47	1,932	2,731	406	216
INDIA.....	68	4	-	-	-	6	2	-	20	2	-	2
KOREA.....	12	4	-	-	-	-	2	-	2	6	-	-
LEBANON.....	26	-	-	-	-	-	6	-	2	18	-	2
MALESIAN.....	14	4	-	-	-	-	-	-	6	4	-	-
PHILIPPINES.....	6,239	249	188	220	2	43	249	47	1,900	2,730	400	210
OTHER ASIA.....	29	6	-	6	-	-	4	-	4	8	-	2
AFRICA.....	57	4	-	-	-	14	-	2	4	18	4	10
NIGERIA.....	33	2	-	-	-	6	-	2	2	12	2	8
OTHER AFRICA.....	24	2	-	-	-	8	-	-	2	6	2	2
OCEANIA.....	80	33	-	-	-	-	-	-	-	26	-	12
AUSTRALIA.....	51	14	-	-	-	-	-	-	10	14	-	10
NEW ZEALAND.....	59	20	2	2	-	-	-	-	10	12	-	2
NORTH AMERICA.....	1,374	177	90	196	80	25	71	108	51	171	179	226
CANADA.....	1,013	171	80	147	80	14	14	104	14	16	167	186
MEXICAN.....	348	-	-	48	-	-	57	-	37	148	-	27
CARIBBEAN.....	132	6	-	6	-	12	-	4	2	18	-	6
BARBADOS.....	31	-	-	-	-	-	-	-	16	75	-	12
JAMAICA.....	184	6	-	33	-	2	35	-	2	18	-	2
TRINIDAD & TOBAGO.....	82	-	-	6	-	4	10	-	18	43	-	8
OTHER CARIBBEAN.....	38	-	-	4	-	4	6	-	2	14	-	10
OTHER NORTH AMERICA.....	48	-	-	4	-	4	6	-	2	20	4	2
SOUTH AMERICA.....	24	-	-	4	-	-	4	-	4	10	-	2
GUYANA.....	20	-	-	2	-	-	4	-	4	10	-	2
OTHER SOUTH AMERICA.....	4	-	-	2	-	-	-	-	-	-	-	-
UNKNOWN.....	8	-	-	-	-	-	-	-	-	-	-	-

- DATA NOT AVAILABLE

TABLE THREE: H-1 NURSES BY COUNTRY OF CITIZENSHIP AND STATE OF INTENDED RESIDENCE CONTROLLING FOR AGE AND SEX
FISCAL YEAR 1986

ALL YEARS FOR 1986

COUNTRY OF CITIZENSHIP	ALL STATES	CALIFORNIA	CONNECTICUT	FLORIDA	HAWAII	MARYLAND	MASSACHUSETTS	MICHIGAN	NEW JERSEY	NEW YORK	TEXAS	OTHER
Total.....	2,451	129	16	102	-	16	67	96	396	1,165	185	267
EUROPE.....	422	14	2	17	-	-	12	-	7	55	2	25
IRELAND.....	53	2	-	-	-	-	-	-	3	34	-	12
UNITED KINGDOM.....	85	10	-	7	-	-	-	-	3	22	2	10
OTHER EUROPE.....	26	2	2	10	-	-	-	-	-	9	-	3
ASIA.....	1,055	84	12	99	-	12	93	21	390	1,089	107	117
INDIA.....	7	-	-	-	-	-	2	-	2	3	-	-
KOREA.....	9	-	-	-	-	-	-	-	-	-	-	-
PHILIPPINES.....	1,034	84	12	57	-	12	90	23	388	1,077	107	117
OTHER ASIA.....	5	-	-	2	-	-	2	-	-	2	-	-
AFRICA.....	7	-	-	-	-	-	-	-	-	5	-	2
NIGERIA.....	3	-	-	-	-	-	-	-	-	2	-	-
OTHER AFRICA.....	3	-	-	-	-	-	-	-	-	2	-	-
OCEANIA.....	10	3	-	-	-	-	-	-	-	2	2	2
AUSTRALIA.....	9	3	-	-	-	-	-	-	-	2	2	2
NEW ZEALAND.....	2	-	-	-	-	-	-	-	-	-	-	-
NORTH AMERICA.....	339	28	2	27	-	2	2	67	-	10	81	121
CANADA.....	321	28	2	27	-	2	2	67	-	9	76	117
CARIBBEAN.....	16	-	-	2	-	-	-	-	-	2	2	2
BAHAMAS, THE.....	8	-	-	-	-	-	-	-	-	2	-	-
JAMAICA.....	3	-	-	-	-	-	-	-	-	2	-	-
OTHER CARIBBEAN.....	3	-	-	-	-	-	-	-	-	2	-	-
OTHER NORTH AMERICA.....	5	-	-	-	-	-	-	-	-	2	2	2
SOUTH AMERICA.....	2	-	-	2	-	-	-	-	-	-	-	-
OTHER SOUTH AMERICA.....	2	-	-	-	-	-	-	-	-	-	-	-
UNKNOWN.....	5	-	-	-	-	-	-	-	-	3	2	-

- DATA NOT AVAILABLE

- 1 -
TABLE TWO: H-1 NURSES BY COUNTRY OF CITIZENSHIP AND STATE OF INTENDED RESIDENCE
CONTROLLED FOR UNDERCOUNT
FISCAL YEAR 1985

ALL YEARS FOR 1985

COUNTRY OF CITIZENSHIP	ALL STATES	CALIF- FORNIA	CON- NECTICUT	FLORIDA	HAWAII	MARYLAND	MASS- ACHU- SETTS	MICHIGAN	NEW JERSEY	NEW YORK	TEXAS	OTHER
Total.....	771,813	69	4	49	-	8	10	62	192	1,169	94	165
EUROPE.....	71	2	3	-	-	-	-	2	2	53	2	8
IRELAND.....	41	-	-	-	-	-	-	-	-	36	-	6
UNITED KINGDOM.....	24	-	-	-	-	-	-	-	-	14	2	-
OTHER EUROPE.....	8	-	-	-	-	-	-	-	-	4	-	2
ASIA.....	1,820	31	-	47	-	6	10	6	184	1,081	67	86
INDIA.....	222	-	-	-	-	-	-	-	2	2	-	-
KOREA.....	22	-	-	-	-	-	-	-	-	2	-	-
MALAYSIA.....	22	-	-	-	-	-	-	-	-	2	-	-
PHILIPPINES.....	1,618	31	-	47	-	6	10	6	182	1,081	67	86
OTHER ASIA.....	6	-	-	-	-	-	-	-	-	6	-	-
AFRICA.....	22	-	-	-	-	-	-	-	-	2	-	-
NIGERIA.....	2	-	-	-	-	-	-	-	-	2	-	-
OCEANIA.....	4	4	-	-	-	-	-	-	-	-	-	-
AUSTRALIA.....	2	2	-	-	-	-	-	-	-	-	-	-
NEW ZEALAND.....	2	-	-	-	-	-	-	-	-	-	-	-
NORTH AMERICA.....	190	22	22	22	-	22	-	88	4	12	28	87
CANADA.....	177	-	-	-	-	-	-	83	-	4	2	85
MEXICO.....	13	-	-	-	-	-	-	-	-	-	-	-
CARIBBEAN.....	13	-	-	-	-	-	-	2	-	8	-	2
GUAM.....	2	-	-	-	-	-	-	-	-	2	-	-
OTHER CARIBBEAN.....	2	-	-	-	-	-	-	-	-	2	-	-
OTHER NORTH AMERICA.....	2	-	-	-	-	-	-	-	-	2	-	-
SOUTH AMERICA.....	8	-	-	-	-	-	-	-	-	6	-	2
GUAYANA.....	2	-	-	-	-	-	-	-	-	6	-	-
OTHER SOUTH AMERICA.....	2	-	-	-	-	-	-	-	-	-	-	-
UNKNOWN.....	8	-	-	-	-	-	-	-	2	6	-	-

- DATA NOT AVAILABLE.

TABLE ONE: H-1 NURSES BY COUNTRY OF CITIZENSHIP AND STATE OF INTENDED RESIDENCE
CONTROLLED FOR COUNTRY OF INTENDED RESIDENCE
FISCAL YEARS 1986 - 1988

ALL YEARS FOR 1985-1988

COUNTRY OF CITIZENSHIP	ALL STATES	CALIF- FORNIA	CON- NECTICUT	FLORIDA	HAWAII	MARYLAND	MASS- ACHU- SETTS	MICHIGAN	NEW JERSEY	NEW YORK	TEXAS	OTHER
Total.....	17,089	1,176	460	864	104	161	717	444	3,270	7,475	1,097	1,320
EUROPE.....	1,859	342	23	161	13	4	214	8	112	539	40	204
IRELAND.....	178	76	8	117	11	-	151	2	85	331	30	76
UNITED KINGDOM.....	178	260	8	123	-	-	82	2	21	170	-	104
OTHER EUROPE.....	119	15	6	21	2	4	-	-	6	38	4	25
ASIA.....	12,638	479	322	376	2	102	383	117	2,072	6,607	630	839
INDONESIA.....	117	4	-	-	-	8	2	-	26	26	8	4
ISRAEL.....	32	-	4	2	-	-	2	-	-	17	-	-
KOREA.....	23	-	-	-	-	-	-	2	4	17	-	2
LEBANON.....	19	2	2	-	-	2	-	-	2	17	-	-
MALAYSIA.....	19	72	316	387	2	91	369	115	3,028	6,514	622	530
PHILIPPINES.....	12,408	456	-	-	-	-	-	-	-	-	-	4
OTHER ASIA.....	53	8	-	8	-	-	6	-	8	21	-	4
AFRICA.....	79	4	-	-	-	19	-	2	4	28	9	12
NIGERIA.....	44	2	-	-	-	8	-	2	19	19	2	8
OTHER AFRICA.....	36	2	-	-	-	-	2	-	2	9	8	6
OCEANIA.....	119	44	-	4	2	-	-	-	11	29	13	15
AUSTRALIA.....	68	21	-	2	-	-	-	-	9	17	9	12
NEW ZEALAND.....	51	23	-	2	-	-	-	-	2	11	-	-
NORTH AMERICA.....	2,519	308	113	316	87	40	102	304	51	233	401	545
CANADA.....	2,058	285	113	288	-	20	102	-	23	40	376	487
CARIBBEAN.....	462	13	-	28	-	13	83	-	-	187	17	44
BAHAMAS.....	30	-	-	11	-	-	-	-	-	6	4	8
BARBADOS.....	48	-	-	-	-	2	9	-	13	26	2	19
JAMAICA.....	238	11	-	32	-	-	97	-	13	67	-	-
TRINIDAD & TOBAGO.....	85	-	-	8	-	4	11	-	17	44	-	2
OTHER CARIBBEAN.....	81	2	-	8	-	4	8	-	4	23	-	8
OTHER NORTH AMERICA.....	72	2	-	6	-	4	8	-	4	28	9	11
SOUTH AMERICA.....	51	-	-	9	-	-	-	3	5	28	-	4
GUAYANA.....	42	-	-	2	-	-	4	-	6	28	-	-
OTHER SOUTH AMERICA.....	9	-	-	7	-	-	-	-	-	-	-	-
UNKNOWN.....	23	-	-	-	-	-	2	-	-	11	4	-

- USES NOT AVAILABLE.

Information and data on Filipino nurses compiled by the INS Officer-in-Charge in Manila.

Mr. MORRISON. But you agree that the 16,000 number is an upper estimate.

Mr. PULEO. Yes.

Mr. MORRISON. OK. We will come back; we will have more questions.

Mr. Smith.

Mr. SMITH of Texas. Mr. Chairman, I will yield to the ranking minority member of the full committee, Mr. Fish.

Mr. FISH. Thank you very much.

Mr. Puleo, on page 4 of your testimony you say, talking about the 20,000 to 25,000 foreign nurses who have entered since 1980, the INS estimates half of these nurses are still in H-1 status; INS also believes a significant number of foreign nurses are currently out of H-1 status. Aside from those who might have married American citizens, do we read into this that up to half of the nurses who kept coming in under the H-1 program are presently in undocumented status?

Mr. PULEO. No, you should not. What we are estimating is that the figure that we have here is, similar to what I have just explained to the chairman—is an estimate of the number of H-1's that arrived in the United States. A portion of those can be still in the United States. However, a smaller portion may be still here who are working and they are not in status.

Mr. FISH. Who are not what?

Mr. PULEO. Not in status. You should not read that a large number of those individuals are not in status.

Mr. FISH. "A significant number of foreign nurses are currently out of H-1 status." What does that mean?

Mr. PULEO. What we are saying is that there may be individuals who originally came to the United States in H-1 status who are working out of status. We don't know the number.

Mr. FISH. So they are undocumented aliens.

Mr. PULEO. Yes, sir.

Mr. FISH. Thank you.

So, actually, this legislation might be an inducement for them to go back to nursing so they qualify.

Page 5: "The Department believes that foreign nurses should have had, and must continue to have, a strong commitment to nursing in the United States. We recommend that the bill require a nurse to have worked in the United States in H-1 status for at least 5 years, to be permanently licensed in a State or territory of the United States; and to make a 2- or 3-year commitment to continue working in the nursing field after obtaining special immigrant status." If these conditions are met, do I understand the Department of Justice would favor the permanent residence afforded by this legislation?

Mr. PULEO. Yes.

Mr. FISH. Thank you.

I think that you make a good point here, that the way it is drafted, it could deny to nurses who have worked 5 years or more and yet benefit one who has only worked a shorter time. That is an interesting point.

You also say on page 7, as I understand you, that the Department maintains that under the H-4 category as envisioned by Mr.

Schumer's legislation and the processing time required, that the number of 5,000 H-1 nurses admitted annually now would drop off.

Mr. PULEO. That is correct.

Mr. FISH. So that you could believe that provision would be counterproductive to our efforts to increase nurses.

OK. Thank you.

Mr. Williams, you, too, are critical of the Department's certification duties in connection with the H-4 nonimmigrant visa category. I gather two things; one is that under H-1 you see no need for imposing labor certification at this time because currently these are what you call precertified.

Mr. WILLIAMS. The clear shortage, yes, sir.

Mr. FISH. Yes.

Do you think it is the Labor Department's business to ensure that employing facilities meet certain conditions designed to protect the wages and working conditions of H-4 nonimmigrants?

Mr. WILLIAMS. Yes, sir. I think that one of the things we would like to work with the committee on is a continued look at these proposed pieces, the way in which that might be done to continue to ensure that there is a protection of wages and working conditions as opposed to a case-by-case certification process for individuals in a situation such as this where there is a clear shortage.

Mr. FISH. By doing away with the case-by-case Labor Department responsibility and do it by institutions, you would—

Mr. WILLIAMS. Through sampling surveys which we have used in other occupations in the past, that may be another approach, and still effectively in this clear shortage situation protect the wages and working conditions.

Mr. FISH. While you are working with the committee, as I hope you will, I refer to a comment you made on page 5 of your testimony in which you voice your concern that, while being in support of this legalization, you talk about projected shortage in numerous occupations, that pressure will build up for similar treatment for those occupations between now and the end of the century.

Mr. WILLIAMS. Yes, sir.

Mr. FISH. In the last Congress, there were several legal migration bills introduced by members of this committee and Members of the Senate, and I refer those to you because one common denominator they all have is borrowing from the Canadian point system which gives points for people with skills in need in the United States, professionals and workers who are needed by us. I think that may help to address your concern there.

Mr. WILLIAMS. Yes, sir.

Mr. FISH. "But the Department can give"—and I am quoting—"qualified support to legalizing H-1's already here on the basis that this appears to be needed to provide immediate relief for certain health care institutions."

Mr. WILLIAMS. Yes, sir.

Mr. FISH. Thank you very much. Thank you, Mr. Chairman.

Mr. MORRISON. Mr. Schumer.

Mr. SCHUMER. Yes. First for Mr. Puleo, you say that one of the inequities of the legislation is that people who would stay here more than 5 years would not be allowed to gain permanent status. Would the Department advocate some provision that would allow

these people to gain permanent status by coming back and working in nursing for 1 year or 2? It is sort of anomalous for you to argue that, I think, unless you would agree that they ought to be let back; they are people who are here illegally.

Mr. PULEO. We would defer to Congress on that.

Mr. SCHUMER. You wouldn't oppose it?

Mr. PULEO. I'm not at liberty to oppose or——

Mr. SCHUMER. You understand the——

Mr. PULEO. Yes, I understand.

Mr. SCHUMER [continuing]. The funny—the peculiarness of that kind of comment coming from the INS here.

Mr. PULEO. Yes, I understand.

Mr. SCHUMER. OK.

The second question I had is, you are saying that the new H-4 program would deter the number of people coming into the country. It clearly can't be the standards that say you have to be paid the prevailing wage as American citizens; that would encourage people to come in. So it obviously must be the process of certifying. How much of a delay do you expect?

Mr. PULEO. The process that you have outlined in your bill would be very similar to the third and sixth preference. You would have to go through labor certification and what-not. There may be easier ways of doing it—for example, having a precertification of occupations from the Department of Labor, maybe splitting up the H-1 category into H-1A and H-1B, allowing H-1's to be the high level professionals.

Mr. SCHUMER. But let's say we stuck this way. I mean it seems to me if people are going to come here and they have to wait 4 months or 5 months instead of 1 month, it is not going to deter them very much.

Let's say we didn't do what your recommendation is, which we certainly would explore, what kind of delay do you really expect?

Mr. PULEO. It would be delay in the processing.

Mr. SCHUMER. I understand. What length of time?

Mr. PULEO. I would say somewhere around 6 months—6 to 8 months.

Mr. SCHUMER. OK. And you think that would significantly deter the number of people coming in?

Mr. PULEO. Rather than having it similar to an H-1, yes.

Mr. SCHUMER. Is there any other thing that would deter them from coming in?

Mr. PULEO. No.

Mr. SCHUMER. That's the main reason. OK.

You also indicate that you would grant permanent resident status after 5 years of service, but it is my understanding these nurses have been fully trained and passed their exams, have been through a probationary period, by the time they have been here 1 year. So what is the rationale for 5 years?

Mr. PULEO. They have gone through further training, extension of training, there is more of a commitment to the nursing field, and we just felt that the longer the time, the more commitment they are to the nursing field, as we suggest that there be a commitment beyond——

Mr. SCHUMER. Well, I am going to get to that in 1 minute, but my first question was, why the 5 years previous? Are just trying to get more work out of them before you give them the permanent status. Is that the idea?

Mr. PULEO. It may be, yes.

Mr. SCHUMER. It may be. OK. Thank you.

The 2- to 3-year status, do you have any figures? Would any gentleman at the table, any person at the table, have any figures on how many nurses leave the field? We didn't put that in because it was the general view of both hospital groups and labor groups who had worked on this legislation and who have supported this compromise that very few nurses do leave. Do you—

Mr. WILLIAMS. No, I have no figures.

Mr. SCHUMER. So why propose the 2 to 3 years? Just as insurance again?

Mr. PULEO. Well, our experience on the individuals coming into the United States on the labor certification who, in fact, do leave the petitioner who allowed them to come in as immigrants—it was our experience in other fields beyond the nursing.

Mr. SCHUMER. OK.

The next question is: If the nursing shortage will only get worse, which everybody is predicting, as your testimony indicates as well, what will prevent health care facilities from becoming overly reliant on temporary foreign nurses if we just stick with this present scheme of things?

Mr. PULEO. I guess we have to rely on their good faith as we did when we granted them the 6th year, that they do—when we granted the 6th year, we asked them to delineate exactly what they were doing to encourage permanent residents and citizens in getting into the nursing field.

Mr. SCHUMER. What this legislation is attempting to do is to say let's not keep muddling through, because we have a shortage, it is a severe shortage, it is growing worse. On the one hand, it does give permanent status; on the other hand, it sort of sets a pathway, hopefully, towards resolving this problem in a more permanent way. So does Mr. Ackerman's legislation in a different way, for that matter.

But my question to you is, if you are not for this H-4 proposal and for just keeping things as they are, what is going to prevent us from becoming even more dependent on foreign nurses?

Mr. PULEO. Our objection to the way the H-4 is structured is that it requires the labor certification and it is time consuming.

Mr. SCHUMER. If it didn't require the labor certification, you would be for the other two provisions?

Mr. PULEO. No. We are for the labor market—

Mr. SCHUMER. Let's say we did a blanket certification, and some of the people in this coalition that are supporting this group would clearly prefer that. You know, you are a nurse, you get in, but you still have to meet the second and third standards; that is, you know, that you be paid the prevailing wage and not be used to bring down working conditions or payment; and, second, that the institution have some reasonable 5-year plan of how they are going to deal with this issue. Would you support those two provisions?

Mr. PULEO. Yes. What we are looking at is something similar to schedule A under third and sixth preferences.

Mr. SCHUMER. OK. That is encouraging.

Mr. Chairman, can I get 2 minutes just to ask Mr. Williams a couple of questions?

Mr. MORRISON. Why don't we come back?

Mr. SCHUMER. Fine. We are going to do a second round? Great.

Mr. MORRISON. Mr. Smith.

Mr. SMITH of Texas. Thank you, Mr. Chairman.

Mr. Puleo, I have a question to ask you about H.R. 1507, and I would welcome any comments from my colleague from New York as well; I don't want to get ahead of him on that; and you can help enlighten me as well. But it seems to me that under H.R. 1507, by, in effect, giving amnesty to all foreign nurses who have been in the United States for 5 years versus, say, extending their visas as we have done twice before, you are perhaps opening the door to those foreign nurses doing something else besides nursing because, as I understand it, if you extend the visa, there is some type of requirement that they would continue in the profession for which they have been given permission to enter the United States, whereas if they are given permanent residence there is no such requirement. Is that the case?

Mr. PULEO. Under special immigrant—if you become a permanent resident, obviously, you can leave the profession. That is why we were advocating the 2- to 3-year commitment to the nursing field.

If I remember the proposed legislation, it does require you to be in status; you cannot be out of status to be granted the benefit.

Mr. SMITH of Texas. In effect, my question then—and let me address my colleague from New York as well—wouldn't it be better, if you want to guarantee that the foreign nurses who have gained entry to the United States continue to practice as nurses—isn't it better to extend the visa rather than to grant them permanent residence? because if you extend the visa they are still required to continue their nurse, whereas if you give them permanent residence there is no such requirement.

Mr. PULEO. That is correct. If you are here as a temporary worker under an H-1, you have to work for the petitioner—the hospital or the nurse association that petitioned for you.

Mr. SMITH of Texas. OK.

Mr. SCHUMER. Just a comment. This is a temporary labor provision, as you know. Why don't we have a permanent/temporary labor provision?

Mr. SMITH of Texas. For other areas as well?

Mr. SCHUMER. Well, I would support that in terms of other areas, but the basic problem is that this is not a temporary problem, it is a long-term problem. We desperately need nurses over the long term. I guess we could open up the doors and say, well, any nurse who comes here and keeps working at nursing could stay as long as they wanted. But I think that creates a lot of other problems in terms of getting citizens into these jobs and the kind of effect it would have on the work force. And there is something in the American notion that we don't have, if you will, indentured servants forever. We say, well, we are willing to have them for a few

years but not forever. That would be the problem with your proposal.

What this legislation is saying is, hey, the nurses have been here 6 years; the crisis has gotten worse. We don't have to debate it here.

Mr. SMITH of Texas. I thank my colleague. My concern was just, I hesitate to open the door when we have already heard about presumably a relatively large percentage of nurses who are no longer in nursing; I hate to open that door and allow others to perhaps follow in their footsteps. But let me go on.

Mr. Puleo, in your testimony you mentioned that the foreign nurse problem is a symptom of a larger problem with current immigration laws—that is, the use of temporary worker categories to solve permanent, long-term labor market shortages. Do you want to explain that further, and how would you resolve that problem?

Mr. PULEO. Yes. The bill removes professional nurses from the H-1 category, moving them to a separate category with the labor market test. We believe that this is the proper course of action, but it should not be limited to the nursing profession. Petitions for temporary workers in all entry-level professional fields should be subject to a labor market test, just as Congress proposes for nurses. We don't want the nursing crisis of today to be the engineering or teaching crisis of tomorrow.

Mr. SMITH of Texas. OK. Thank you.

Mr. Williams, let me ask you a couple of quick questions. First of all, do you believe that hospitals are doing enough to keep and attract U.S. nurses, and, if not, why not? Perhaps Dr. Clinton could answer that as well.

Mr. BRUENING. Well, primarily, based on the study that was done for the Secretary of HHS, a special commission was set up. We read that as indicating there are a lot of efforts being made in that direction by hospitals. Press reports indicate that there are a lot of efforts being made in that direction, and I think we support the continuation of that as part of H.R. 2111.

Mr. SMITH of Texas. That is what I was getting to. What specifically should we do to encourage individuals to go into nursing? Do you agree with some of the parts of H.R. 2111?

Mr. BRUENING. Yes, we do.

Mr. WILLIAMS. Some of the indications we have seen in terms of anecdotal information from reports are that there have been some increases in wages and other opportunities offered, but we would certainly favor some of the things that were indicated in H.R. 2111 in terms of the opportunities for tuition, for scholarships, for grants to institutions, and for encouraging both on-the-job within the nursing facilities and in terms of attracting more people who are not now in the nursing profession at a younger age to become aware of the value of entering that service and the value of the profession.

Mr. SMITH of Texas. Thank you, Mr. Chairman.

Mr. MORRISON. Dr. Clinton, on the big picture for a moment, where are we going here? Does HHS view itself as developing a long-term plan with respect to dealing with the nursing shortage, or is this something that DOL is supposed to be doing, or is it some-

thing the hospitals are supposed to be doing without leadership from the Government?

Dr. CLINTON. That last caveat makes me pause. We expect to provide leadership, but I don't know that the Federal Government can resolve the entire nursing shortage issue alone. The Nursing Commission report advisory to the Secretary outlines a great number of issues, and you will be hearing more about that today.

The resources available through the nursing education process, through the appropriations process, limits very much the production of nurses, but I would point out that we already have in the 1986-87 academic year 90,000 nursing students entering nursing school, and the good news last year was that the new first-year student rate was up by 4 percent. Now we look forward to next fall, because we are seeing some turnarounds both in medicine and nursing in terms of the numbers of individuals expressing commitments to move into the health career.

We undertake a number of activities in special projects now with this year's appropriations to look at better ways to utilize nurses, ways to attract those that have been identified in the conversations already; we are looking at a special effort to look at minorities and bringing them more completely into the nursing field as well as other professions; we constantly monitor the supply and are trying to improve our capacities to look at the demand for nursing.

The demand for nursing has gone up markedly. Everyone, I think, is in concurrence on that point. There are now two million nurses registered to practice nursing in the United States; 80 percent are in nursing. There isn't very much opportunity to squeeze the other 20 percent. We could provide you the details of those, which accumulates from our sample survey of nurses every 2 or 3 years. Those reports are provided to the Congress regularly. So I don't think that there is a large number of men or women out there currently unemployed that we can easily bring into the nursing field.

Mr. MORRISON. Is it the intention of HHS to give us a long-term plan? I mean it is a little anomalous that the Immigration Subcommittee is having this hearing. It doesn't mean that other committees are not looking at it, but this nursing shortage didn't happen yesterday; this has been around for a while if you look at the large number of foreign nurses. We are talking about people who have been here 5 and 6 years, giving rise to this legislation. That suggests that for 5 to 6 years there has been a substantial reliance on foreign nurses as one aspect of the shortage as well as unfilled positions.

To this point, there is no initiative coming forward to the Congress saying here is where this Nation needs to go to address the nursing shortage, and I assume that we have other technical health care professional shortages developing as well. Certainly if we look at the Veterans' Administration system, which we have been looking at in the Veterans' Committee, we know that other technically trained paramedical professions are experiences shortages and difficulties and problems of a mismatch between wages and working conditions and the availability of personnel. So it seems like we have, at least in certain areas, a serious health care professional shortage, and we can't solve it on the immigration side

unless we are going to become reliant on foreign labor for these positions, and maybe we couldn't solve it if we wanted to using that.

I guess the question is, where is the initiative here? Can we expect the Secretary to be coming to Congress during this year with some kind of overall plan for adequate health care labor so that we would know where the immigration piece fits into it? I find the difficulty here that we are not really fitting it into any overall labor plan or any health care plan, we are just dealing with an immediate crisis, which doesn't get to solving the long-term problem.

Dr. CLINTON. You are quite correct that there have been many hearings on the nursing shortage, and we have been up here over the last 2 years to discuss it in the committees that have primary jurisdiction in nursing education and training, and there was an act passed last November, the Nursing Shortage Reduction Education, which addresses many of the issues that have been before this committee today.

Indeed, the Nursing Commission provided its report to Dr. Bowen just prior to the end of the last administration, and Dr. Sullivan has just arrived in town. We have submitted, as I indicated earlier, our recommendations about how the Federal Government can take a leadership role in some of these areas. That is under consideration by the Department, but we are really talking about a number of days that that has been submitted to the Department. So I think you will be hearing from the Department.

Mr. MORRISON. When could we expect to have a position of the Department as to how the foreign nurse supply question meshes with where you intend to go in the long run on overall health care person power needs?

Dr. CLINTON. I don't think we understood that you had asked the question.

Mr. MORRISON. Well, we had such a hard time getting you guys to agree to come to this hearing, maybe we didn't phrase it right. I mean we really did, and we were told that the Department wasn't really in a position to send anyone, didn't have a position, preferred to leave it to INS and to DOL, and yet we kept thinking, who should make health care policy in the United States? They are really secondary actors here, and you are primary.

Dr. CLINTON. Well, frankly, I think that the numbers that you are talking about, be it 15,000, 16,000, or 20,000, are small in the overall perspective. They may make a great deal of difference to a specific hospital, and I don't question that at all. But we have got 90,000 people going into nursing schools each year; we have got many other numbers; we provide a loan program for nursing that extends to more nurses than that on a given year. So, therefore, we see this as a very small part.

Now I don't know that anyone has done a quantitative analysis, and that is why I raise the question, had this committee raised or had expanded a quantitative analysis of how this fits into our other number sets? I don't think that has been done; it should be done.

Mr. MORRISON. We may be getting things a little bit backward of who the executive branch is and who the legislative branch is. It is the primary responsibility of the executive branch to lay out these kinds of policies and to work with us on it rather than us to sort of drag you up here and ask you to respond in that way.

Dr. CLINTON. That seems quite reasonable. I think we would have to pick an assumed number. Let's pick 16,000, if that is a reasonable number, and I think that we could provide where we think 16,000 fits into the overall supply of nurses. As I indicated, there are 1.6 million currently working, so 16,000 is a small fraction of that.

Mr. MORRISON. But it quite clear that these foreign nurses are fitting into some particularly critical places, into urban hospitals, and other hospitals, as opposed to a wide variety of other nursing areas, and those kinds of judgments really are not an immigration question. We don't have any expertise at all in that area; that is where your expertise ought to be coming to bear on what we are doing.

Dr. CLINTON. I would urge you to talk to the American Hospital Association and others on most of those issues. We have no way to sample all the hospitals in America and describe what is going on. We do know that many hospitals have resolved their nursing crisis issues by better management, better wages, better benefits, better utilization of nursing for nursing skills, not using them to carry food trays, to bathe patients, to take care of administrative tasks. They need more allied health, they need more other things to supplement that.

Mr. MORRISON. We have got a serious market failure here, and for too long we have been listening to the Reagan administration tell us that everything gets solved by the marketplace, and here we have a dramatic marketplace failure and no leadership in the executive branch.

Dr. CLINTON. The market has misused nurses badly, and I think most of us in the room will agree with that.

Mr. MORRISON. Yes, and it is one of the most heavily regulated markets, and the Federal Government is the largest single purchaser of health care in the United States. So here we are, and we are not getting the leadership we need.

Well, I hope that this dialog will at least convince you that we would like to know more about where HHS is going in the overall planning and where it thinks the role of foreign nurses—what role foreign nurses play, and where it is going in the long run, so that our immigration policy could be coordinated with other policies to try to deal with this problem in the long run.

You are correct about the small numbers, but there are a lot of other immigration issues that arise when one starts to deal with labor shortages by saying, "All right, we will plug in people, give them permanent status;" it arises in other fields.

Dr. CLINTON. It looks to me like it is less than 1 percent, and I think you have to decide whether that is worth the energy to create that.

Mr. MORRISON. Well, you are saying we don't need them.

Dr. CLINTON. No, that's not the question.

Mr. MORRISON. Well, it's only 1 percent. You say, "Well, 1 percent, you know, we can make that up, or we can never make it up, it doesn't matter." What are you saying?

Dr. CLINTON. I question whether the same resources ought to be utilized to expand nursing education programs, for example, or

scholarships, or loans, or many of the other things we are talking about here today.

Mr. MORRISON. What do you mean by "resources"?

Dr. CLINTON. It is going to cost someone some amount of money to bring those nurses from the Philippines or wherever they come from.

Mr. MORRISON. It doesn't cost us much to legalize the ones that are here.

Dr. CLINTON. True, to do the compliance issues that have been talked about today. They are somewhat subjective.

Mr. MORRISON. I am way over my time.

The gentleman from New York.

Mr. SCHUMER. Thank you, Mr. Chairman.

First, just a quick question. Could the committee get a copy of the recommendations to the Secretary regarding the Commission's report, Dr. Clinton? Would that be possible?

Dr. CLINTON. No. That is an internal working document at this point.

Mr. SCHUMER. OK. Let me go back to—that's what I thought you would say. Let me go back to some of the other questions here. First, when we left off we were talking about how many of the people who come in on H-1's are no longer in nursing. Would it be unfair to say that is probably a very small number?

Mr. SMITH of Texas. If my colleague will yield, I seem to recall in some of the testimony that we have—I can't remember which individual, but I thought it was about 20 percent.

Mr. SCHUMER. As I understood it, that was the number of overall R.N.'s in the country who are not practicing nursing at a given time.

Mr. SMITH of Texas. Perhaps so.

Mr. SCHUMER. It would seem to me that that is a relatively high number, but it would seem to me that of the people who are here on the H-1's, probably even a higher percentage are still in nursing, because for a citizen to retire and to get out of nursing and do one thing or another is a little easier than for somebody who isn't and makes a decision to become out of status or whatever you want to call it. So would you estimate that it is probably a smaller number than 20 percent?

Mr. PULEO. Smaller than 20 percent? It is just a guess on our part that most of the nurses, when they do go out of status, do not leave nursing.

Mr. SCHUMER. Do not?

Mr. PULEO. They remain in nursing.

Mr. SCHUMER. Wouldn't it make logical sense to say that it is probably higher than 80 percent, if 80 percent is the figure for citizens?

Mr. PULEO. It may be, yes.

Mr. SCHUMER. OK. I now have some questions for Mr. Williams. I finished my questions for Mr. Puleo on the first round.

Your testimony, Mr. Williams, indicates that the Department believes that H-1 is working fine and that H-4 would impose burdens on the Department not worth undertaking, and then you question the wisdom of extending permanent status to certain H-1 nurses.

I would like to read you from the President's Comprehensive Triennial Report on Immigration that the Department of Labor prepared. They say, "While an abrupt withdrawal of foreign nurses could be expected to cause severe disruption to the health care delivery system, continued access to them provides little incentive for hospitals to take the comprehensive steps necessary to develop and nurture a long-term relationship with domestic workers. Despite recent assertions"—I am quoting from the report that your Department prepared—"Despite recent assertions that the employment of foreign-born nurses has no adverse effect on U.S. nurses, ready access to foreign workers clearly exacerbates the problem. Foreign nurses temporarily alleviate shortages without addressing the real problem, the changes needed to attract and retain new generations of U.S. nurses."

Now how in the heck does that report issued by your Department bear a relationship to your testimony here today? If you would read that report, it would seem like a ringing endorsement for H.R. 1507, and then all of a sudden you come up with testimony today that seems quite different from that, that everything is hunky-dory. Try to explain the contradiction there. It would help me figure this thing out.

Mr. BRUENING. I think the statement in the triennial report is our basic position as a general principle. I think we are persuaded in this situation with nurses, again, when you look at the numbers—

Mr. SCHUMER. But this report—what I read you was on nurses. It says, "While an abrupt withdrawal of foreign nurses . . ." It is right from the triennial report. It is saying quite specifically, number one, that we need these foreign nurses but that to continue to rely on foreign nurses, as we do under the current H-1 program, without any change, isn't going to solve the problem, and, indeed, they use the word "exacerbate." Now you are coming and saying, "Leave things alone." Explain that to me.

Mr. BRUENING. I don't think we are saying, "Leave things alone" as a long-term measure. As I say, if you look at the overall numbers, we are talking about 2 million nurses in this country, 1.6 million that are employed now; you are talking about labor shortages in that field of perhaps 100,000 to 200,000; some have gone higher than that.

Then if you look at that in relation to the number of H-1 nurses that have come in in recent years, these are 2,000, 3,000, perhaps 5,000 in the last year, and it is growing, and if it would get considerably larger I would think the Labor Department would say then we have to take some other measures. But at this point, in terms of those shortages, to put employers through the kind of labor certification process which is proposed in H.R. 1507 doesn't seem to us to be appropriate.

Mr. SCHUMER. OK. If the labor certification seems to be the gravamen of Mr. Puleo's objection to H.R. 1507, let me ask you again, as you know, H.R. 1507 has three criteria. One is the labor certification; it is more detailed than currently done; the second is that the foreign nurses not be treated any differently in terms of prevailing wage and condition; and third is that the hospitals develop some kind of plan over 5 years to get some domestic labor.

Do you have any problem with points two and three in H.R. 1507? Does your Department? Mr. Puleo had answered before that they didn't have problems with points two and three, it was point one, the labor certification. Do you concur with that?

Mr. BRUENING. Two being the prevailing wage?

Mr. SCHUMER. Yes.

Mr. BRUENING. We have no problem with that.

Mr. SCHUMER. All right. Three.

Mr. BRUENING. The third one being?

Mr. SCHUMER. Hospitals coming up with a plan within 5 years to get new people from the United States into the profession.

Mr. BRUENING. The extent of our labor certification process, the way it is done now in both the permanent program and for H-2(b), is test of availability of U.S. workers. We do not require any employer to show that they have some long-term plan.

Mr. SCHUMER. I'm asking you would it be a good idea.

Mr. Williams, do you want to answer that?

Mr. WILLIAMS. I think it would be a good idea to continue to encourage those things that were suggested by Congressman Ackerman and others to encourage those hospitals and facilities to develop such plans.

Mr. SCHUMER. What specific objections would you have in H.R. 1507, my bill? I want to give you the exact place. I just don't want to spend a lot of time looking for it here.

Point number 2(a)(iii); it is on page 5. You have said you agreed with (ii); now here is (iii).

Mr. BRUENING. On page——

Mr. SCHUMER. Triple I, for those who don't have the legislation in front of you, is that the facility has demonstrated that it has taken and is taking timely and significant steps designed to recruit and retain sufficient registered nurses who are U.S. citizens or immigrants who are authorized to perform nursing services in order to remove as quickly and reasonably possible the dependence of the facility on nonimmigrant registered nurses.

Mr. BRUENING. All right. I guess it is a matter of what is all entailed in accomplishing that criterion, and on page 7 of your bill, of course, on the top of the page, you have items 1 through 4 which amplify on what should be done in order to make that determination.

Mr. SCHUMER. Right.

Mr. BRUENING. And this would require us to go into each nursing facility or hospital facility that employs nurses to determine whether a suitable training program is being provided or whether other opportunities are being provided, whether they are paying nurses at wage rates above the prevailing wage, and to make some determination presumably on how much above the prevailing wage would be appropriate, whether they are restructuring occupations, and so forth.

Mr. SCHUMER. Right. Well, couldn't the hospitals provide that kind of—couldn't they certify they are doing that and then, on a random basis, the Department just check it? I mean you have done this kind of stuff before. Whenever we give you a responsibility, you don't go to each institution and spend months and months checking them out. No one is saying you have to do that in this

legislation. It is up to you to adopt the regs, and this committee would look at it, and I'm sure the Congress would look at it that those kinds of reasonable regs would be acceptable.

In other words—I am sort of perplexed. It seems that in the past the Department of Labor's thrust has been in the direction which this legislation is proceeding, and I don't know, maybe somebody from higher up said, "No, we can't support it for a variety of reasons." Maybe one of your colleagues to either side of you said it, but somehow or other—the Departments in which your colleagues are in—but somehow or other everything that the Department of Labor has said, the report, other things, would seem to indicate they would look favorably upon this legislation, and, quite frankly, when we had talked to the Department of Labor as we worked through this legislation they were quite favorable. So I want to know what happened.

Mr. BRUENING. I think it is a matter of the extent of need in this particular situation.

Mr. SCHUMER. OK. You don't think it is that desperate. OK. Well, that is a value judgment that Congress might have to make. I understand that.

Thank you, Mr. Chairman.

Mr. MORRISON. Mr. Smith.

Mr. SMITH of Texas. Thank you, Mr. Chairman.

Dr. Clinton, let me go back to your figures, because I hadn't heard them before, and I just wanted to make sure that I had them right. We have acknowledged approximately 16,000 nurses from overseas now working in the United States, and you mentioned a while ago there were 1.6 million nurses working, the total work force, and came up with the fact that foreign nurses now comprise 1 percent of the total number of nurses that are working in the United States. I wasn't aware of that figure until you gave us the 1.6 million, but it seems to me that 1 percent of the total is an awfully small amount. What makes us think that we are alleviating a crisis by increasing the number of nurses by 1 percent because of foreign nurses?

It seems to me that even increasing the number of nurses from overseas significantly isn't going to really solve the crisis, and we may well be looking at the figures for the wrong reason. Shouldn't we be looking at the bigger gap, trying to attract more nurses, trying to increase salaries, trying to improve living conditions, and things like that?

We are doing a lot of argument today and a lot of talking about 1 percent of the total number of nurses, and I just don't see how that is going to have a significant impact one way or the other.

Dr. CLINTON. I don't either.

The 1 percent is my division, and if I did it incorrectly——

Mr. SMITH of Texas. That is my division exactly, 1 percent.

Dr. CLINTON. I'm just using the numbers. We do know that there are 1.6 million nurses employed in America. We will look in our sample survey. I don't think we have a specific question that deals with nationality which would get us an indirect confirmation of that figure.

We are using every energy we can muster for the appropriations provided this year and the last 2 decades to address issues of nurs-

ing—nursing education, nursing training, retraining, bringing them in, continuing medical education, continuing nurse education. We are doing everything the Congress can provide us by way of appropriation in this fiscal year through loan programs and scholarship programs.

Mr. SMITH of Texas. Thank you.

Are we making much ado about nothing to have all this debate and argument about what turns out to be only 1 percent of the total number of working nurses? You know, that is not going to solve the crisis in my way of thinking even if we were to double the number.

Mr. PULEO. Well, I rely on my meetings I had with the Nursing Association and the Hospitals Association over 1 year ago. I think it is not a simple factor of math, it is factor of where these shortages are, in New York, California, and what-not. So the fact that this bill addresses the shortages in those particular areas I think is more of a factor than the fact that we are talking about 16,000 nurses of a population of 1.6 million.

Mr. SMITH of Texas. Given the fact that we either target certain areas—for instance, there is, to me, a real demand for nurses perhaps in the rural areas—should that be part of a bill that you target particular areas, just like we do with doctors?

Mr. PULEO. Well, I think H.R. 2111 does that, and we object to that. We think it should not be specific areas but should be an overall factor. But what I was trying to do was address the question of the math, the 16,000 versus 1.6 million.

Mr. SMITH of Texas. I understand that.

Let me ask you one more question. Of the 16,000, roughly, foreign nurses in the United States, how many are here, as we talk right now, illegally?

Mr. PULEO. I have no idea. Our assumption is that the majority of them who are out of status remain in the nursing field, but we have no idea how many.

Mr. SMITH of Texas. Has the INS deported any foreign nurses, and, if so, how many?

Mr. PULEO. Not in the last 2 years because of our extension plus the extension Congress gave last year, and I have no figures on—

Mr. SMITH of Texas. But I assume that there are some illegal nurses here now but they are not being deported. Is that a correct statement?

Mr. PULEO. We assume so.

Mr. SMITH of Texas. OK.

Dr. Clinton, you were shaking your head in agreement 1 minute ago regarding my question to Mr. Puleo about the need to target particular areas of the country. Would you like to comment any more?

Dr. CLINTON. Well, indeed, there are shortages across the country. They are in the States that have already been mentioned. They are in big cities, and they are in rural areas. So it would be difficult to resolve the issue by one declaration.

Mr. SMITH of Texas. By area.

Dr. CLINTON. We do do some of that with regard to medicine, and it is sometimes helpful and sometimes it is not.

Mr. SMITH of Texas. OK. Do you have any response to Mr. Puleo? You seemed to think that 1 percent was pretty insignificant, and Mr. Puleo says, well, it is more significant if you look at the areas where they are needed and you shouldn't just look at the math.

Dr. CLINTON. We would have no difficulty adding another 16,000—that would be a real contribution—as long as it does no harm to the current efforts that need to be done by hospital administrations and nursing administrations to improve nursing.

Mr. SMITH of Texas. Is it possible that if we were to admit another many thousands of foreign nurses that that might take the pressure off of hospital administrators to try to improve conditions and improve the pay?

Dr. CLINTON. I think it may. I think it may.

Mr. SMITH of Texas. Mr. Williams, what would you think?

Mr. BRUENING. I think to us the numbers still say that the kind of detailed labor certification process is not necessary to achieve that objective.

Mr. SMITH of Texas. Do you still think the shortage is so severe that you don't need to do that?

Mr. BRUENING. That is our reading.

Mr. SMITH of Texas. Thank you, Mr. Chairman.

Mr. MORRISON. Mr. Puleo, there is already a form of permanent status available to these temporary nurses under the third preference, isn't there?

Mr. PULEO. Third and sixth preferences.

Mr. MORRISON. Third and sixth, both.

How did nurses get under the third preference? R.N.'s don't have to have bachelors' degrees or anything. How did they get under the third preference?

Mr. PULEO. Because they are considered professionals. It was a precedent decision that was set back in the early seventies by INS. It is also recognized by many States that nurses are professionals.

Mr. MORRISON. So it is the label. We call them a profession, and then they are under the third preference?

Mr. PULEO. Yes, sir.

Mr. MORRISON. But, in any case, third preference would be available to these individuals. The real problem here is the Philippines' waiting times. Aren't most of the people who need this relief most specifically Filipino nurses?

Mr. PULEO. Right. Our estimate is that 75 percent of the H-1's are from the Philippines, and currently—this is the June visa bulletin—third preference is 1973 and sixth preference is 1985 for Filipinos. So there is quite a time delay. It is over 4 years just for 6th preference.

Mr. MORRISON. Does that tell us something about the way in which we dole out the visas under the third and sixth preference? In other words, our problem here isn't so much that we don't have a legal structure to deal with this problem, we do, and people who are here for a period of time and show an attachment and show the skills, et cetera, they can change their status from temporary to permanent. But we have these long waiting lists for particular countries, and in this case it turns out to be the Philippines. Should we have a different way of passing out visa numbers under the third preference so that, instead of being under the 20,000

limit, instead of being doled out the way it is, it ought to take some cognizance of labor shortages or something like that?

Mr. PULEO. We would hope that Congress would undertake what it began last year, a comprehensive review of the entire legal immigration process.

Mr. MORRISON. When Congress undertook that, one of the things it didn't do was undertake an overall review of the temporary visa program which, in my view, needs to be integrated with the permanent system, and it seems to me there is no better example of the mismatch than what we are dealing with right here.

We are talking about specific legislation to basically jump Filipino nurses ahead in the third preference process. I mean that, in many ways, is exactly what the legislation does as to permanent status, and if that is good today, why won't it be good tomorrow?

Mr. PULEO. Well, we think the entire legal immigration process needs to be reviewed. There seems to be an imbalance between the family preferences and the labor preferences. Although there are two preferences, the third and sixth, that address labor needs, in essence, only approximately 4 percent of the individuals who immigrate into the United States are directly related to the labor preference list.

Mr. MORRISON. How are we ever going to do that right, though, when HHS and DOL have no labor policies that we can reference? In other words, it is a great theory, it is exactly right, we ought to be admitting people, at least significant numbers of people, with respect to labor needs in the United States, and yet it is the hospitals who are supposed to figure this out or it is some other group of employers. Don't we need some labor force policies, some labor person power data, in order to, over time, make a success out of labor-oriented admissions?

Mr. PULEO. Yes, I agree.

Mr. MORRISON. We don't have those, do we?

Mr. PULEO. No.

Mr. MORRISON. I want to just ask one other question, and that is about this 80/20 R.N.'s in nursing and R.N.'s not in nursing. Where are all of the utilization review people and all the insurance company employees who are checking everybody's bills? Are they in the 80 or the 20?

Dr. CLINTON. Eighty.

Mr. MORRISON. They are in the 80. You are saying they are in nursing. Well, they are not really in nursing. I mean they just happen to be well trained health care professionals whom insurance companies and State agencies like to hire in order to do this kind of paperwork and utilization checking. Isn't that right?

Dr. CLINTON. Bedside nurses. That is correct.

Mr. MORRISON. They are more than not bedside nurses, they are exercising a different kind of function, they are not in care-giving, they are in administrative or whatever kind of work, for which a lot of their training is not relevant as much as the fact as just the intelligence of the pool of employees and their kind of experience in health care generally. Isn't that right?

How many of that 80 percent is in this kind of administrative work as opposed to in the delivery of care?

Dr. CLINTON. I can provide it for the record; I don't have the number in my head. We have that from the annual surveys—periodic surveys, that is.

Mr. MORRISON. OK. So the 80/20 is not the complete picture then about what we are dealing with.

Dr. CLINTON. Well, I don't think any percentage number reflects America as easily as that. The details are well known. We can provide that for the record.

Mr. MORRISON. OK. I would appreciate having them, because I think they would help.

Dr. CLINTON. They were provided to the Congress last year, and the forthcoming report to Congress on health manpower in general will be coming out in the next year.

Mr. MORRISON. Will that make clear where the other shortages are?

Dr. CLINTON. Other shortages in other health——

Mr. MORRISON. Other health care professions.

Dr. CLINTON. Yes, it does. It has, and it always will.

Mr. MORRISON. OK. Thank you.

[The information follows:]

The March 1988 National Sample Survey of Registered Nurses conducted by the Division of Nursing in the Bureau of Health Professions, HRSA, showed that most all of the 1.6 million registered nurses who were employed in nursing were working in health care settings which had responsibility to provide health care to segments of the population. Only 1 percent were employed by insurance companies or in central government agencies, health planning agencies, or national or State nursing or health associations. In addition, about 2 percent were employed in schools providing education to nursing students. Of all those employed in health care settings, less than 1 percent had position titles as quality assurance or insurance reviewers. Thus, the vast majority of the 1.6 million registered nurses were engaged in direct patient care, supervising nursing care and personnel providing nursing care consultation, and/or administering nursing services. Sixty-five percent of the 1.6 million spent the majority of their time during a usual work week in direct patient care.

Mr. MORRISON. Mr. Schumer.

Mr. SCHUMER. Thank you.

I would just like to go back to the dialog I had with the folks from Labor. You say there is only a 1-percent shortage and that means, well, it doesn't justify a new program. Do you have transportation plans to bring nurses from the places that have a surplus of nurses over to the places where there is a 20-percent shortage, like my area?

You take a big picture view of the United States. You say there is only a 1-percent shortage. Twenty percent in my area.

Mr. MORRISON. If the gentleman would yield, the 1 percent they are talking about is what this 16,000 represents as compared to the R.N.'s in——

Mr. SCHUMER. I understand, but he is saying that is 1 percent of the total that we need.

Mr. MORRISON. He didn't say that was the shortage, is what I am saying.

Mr. SCHUMER. OK. All right.

Mr. MORRISON. I said the shortage is much larger than that.

Mr. SCHUMER. Yes, the shortage is a 130-something thousand. I understand that. All I am saying, though, is, you say, well, there is not such a dire need right now.

Mr. BRUENING. No.

Mr. SCHUMER. Would you agree that in certain areas of the country there is a dire need?

Mr. BRUENING. No, sir, we are not saying there is no dire need; we are saying quite the contrary. We recognize the dire need, and it is greater in areas such as New York City. Because there is such a clear-cut shortage and need, that is why we are saying we don't see the need to impose the labor certification process even for the temporary workers.

And could I add to that, under a third preference, which we were talking about, that does require certification, but since 1980 the Department of Labor has determined that nurses were a shortage occupation and they are precertified, which means that they don't have to go through the case-by-case process, not even a test for prevailing wage.

Mr. SCHUMER. Yes. But the bottom line, again, is your own Departments report, everything else, show that the present system, as streamlined as you want to make it, doesn't scoop in enough foreign nurses even close enough to fill our needs, and you are saying, "Well, leave things the way they are." How would you change things?

Mr. BRUENING. But that is why, sir, we are saying we support, because of the need, your proposal to convert to permanent status H-1's who are already here, but that is only 16,000 perhaps out of the 200 or whatever the need is.

Mr. SCHUMER. Understood.

Mr. BRUENING. So then we are saying why make it much more difficult for hospitals to—

Mr. SCHUMER. Well, we can argue whether a 3- or 4-month difference, as Mr. Puleo testified, is going to make it much more difficult for people who have been waiting here and can stay here 5 years. It seems to me, really, that is not a very powerful argument.

But the other parts of the bill are saying, you know, let's at least use the need for foreign nurses to force everybody to start getting domestic nurses, which Dr. Clinton said isn't going to fully come from the Federal Government, and we agree with that, even though I would support Congressman Ackerman's bill.

What is your solution? I mean let's say we had no admission process but you had to be a nurse. It was like at the airport; you walked through one of those metal detectors that detected if you were a nurse, and you were in here. We still wouldn't come close to enough people. Right?

Mr. BRUENING. Right. And we are not advocating that foreign nurses take up the slack in toto. We are just saying, at the levels that have been coming in now under H-1 and under third preference in the permanent program, you are totaling less than probably 8,000 a year coming in under those.

Mr. SCHUMER. I agree. The whole purpose of H.R. 1507 is to say look—and we agree on the permanent resident part of it, so I am not disputing that or discussing that, but on the other part of it is to say, "Look, let's not even maintain the illusion, let's do something concrete to say that we are not going to just hope somehow in the future foreign nurses can fill up the slack." Don't you agree with that conceptually?

Mr. BRUENING. Yes, sir. That is why I think we are saying we support that part of H.R. 2111 which would take other measures to try to bring U.S. workers into this field.

Mr. SCHUMER. OK. Thank you.

Thank you, Mr. Chairman.

Mr. MORRISON. I want to thank the panel very much for very informative testimony. Thank you.

Mr. WILLIAMS. Thank you, Mr. Chairman.

Mr. MORRISON. Our next panel: Dr. Lillian Gibbons, who is the Executive Director of the Secretary of HHS's Commission on Nursing; Barbara J. Hatcher, M.P.H., R.N., of the American Nurses Association; Filipinas Lowery, of the Filipino Nurses Association; Ruth Stewart, R.N., University of Texas School of Nursing. If you would all please come forward and remain standing, and if you would each raise your right hand.

[Witnesses sworn.]

Mr. MORRISON. Please be seated.

Thank you very much for joining us. Your written testimony will be made part of the record in its entirety, and we would ask each of you to please try to observe the 5-minute limit on your oral presentation. As you have observed, the committee is not bashful about asking questions. So there will be plenty of opportunity to expand on the details. But if you could summarize in 5 minutes the high points of your testimony, we would appreciate it.

Dr. Gibbons.

STATEMENT OF DR. LILLIAN K. GIBBONS, EXECUTIVE DIRECTOR, SECRETARY'S COMMISSION ON NURSING, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. GIBBONS. Mr. Chairman and Mr. Schumer, I'm pleased to be here today, and as you undoubtedly know I am here to represent the Commission on Nursing, which was a commission that Secretary Bowen charted for the year 1988. We are a small core staff remaining in the Secretary's Office at this point in time, due to expire on June 30.

I bring before you sort of the history and some of the analysis that we, throughout the Commission year, completed, and you all have received the three-volume copy of our report.

The nursing shortage in this country, as you are all aware—we have had shortages since World War I—have been well documented. You mentioned before, Mr. Schumer, the nursing shortage is extensive and widespread, and it is continuing to grow. We know that in 1987 the average vacancy rate in the United States was 11.3 percent. We know now that the vacancy rate is increasing, in some parts of the country as high as 30 percent, in New York City, in particular, in some hospitals at this very moment.

We note the causes of this shortage are multiple. It is a demand-driven shortage. A decade ago, there were 50 nurses per 100 patients; now we are seeing 97, almost 1 to 1 per 100 patients.

We see on the supply side that there has been an increase of 37 percent nurses in this country since 1977, a larger percentage growth than in any other singular profession. We know that there are 2.3 million registered nurses today, and we have talked about

the high percentage that are employed, and we know that the labor force participation rate of women in general is 47 percent compared to the 80 percent that we talk about nurses, and 97 percent of nurses are women. We know that two-thirds of our nurses are working in hospitals, 5 percent in nursing homes, and 9 percent in home health care and other types of ambulatory health care services.

The demand-driven causes are the increase in severity or acuity of patients which has occurred since prospective payment DRG's in 1983. We have seen a growing aging population—a higher proportion of our hospital patients are 65 and older—and a significant increase in the frail elderly 85 and above.

There has been a proliferation in the growth of biomedical technology. Much of the technology that we are using in the health care industry is labor-intensive technology, again, demanding more nurses.

We are all very familiar with the growth in the HIV epidemic across the country. There has been a 14-percent increase in intensive care beds in our country since 1983. For each intensive care bed that is opened in any hospital in this country, it requires four nurses for each intensive care bed, and there has been a fivefold increase in surgical procedures on patients 90 years of age and above, and if we look at the patient population having changed substantially, all of this says that there has been cataclysmic changes in the health care delivery system in our country since 1983.

The educational programs that prepare the providers for health care in this country have not had the same kind of changes in the academic preparation of our providers.

We know that the solutions are multiple, because the ownership of the shortage cuts across the industry. It is owned by the hospitals, it is owned by physicians, the change in medical practices, it is also owned by nurses.

The Commission called for a joint private/public sector solution, joining forces to develop an appropriate implementation plan, and recommended that the Secretary of Health and Human Services create an ongoing commission on nursing. The recommendations were presented to the Secretary in December, and, as Dr. Jarrett Clinton mentioned earlier, it is under review in the Department.

The problem today in the nursing shortage is clearly a retention problem. We have more nurses than we ever had, more nurses in relationship to the population at large, but the utilization of nurses we see in the studies that we have analyzed throughout the year, 30 to 60 percent of a nurse's time in our acute care institutions are devoted to non-nursing, non-patient-care activities. We are talking about the importance of the hospitals spending \$3.1 billion a year on recruitment of nurses and asking if we can take that money and invert it into retention, to retain the current nursing staff in these institutions.

And, in addition, talking about the improvement of the image of nursing, clearly, if nursing is functioning more appropriately and adequately at the bedside, doing the patient care that nursing clearly wants to do, I think we would see a change in the image,

and we would also see a change in the recruitment into the profession.

I will leave the rest for questions that you might ask.

Thank you.

Mr. MORRISON. Thank you very much, Dr. Gibbons.

[The prepared statement of Dr. Gibbons follows:]

TESTIMONY BY
DR. LILLIAN K. GIBBONS
BEFORE THE
HOUSE SUBCOMMITTEE ON
IMMIGRATION, REFUGEES AND INTERNATIONAL LAW
MAY 31, 1989

Mr. Chairman and members of the subcommittee, I am pleased to appear today to discuss America's nursing shortage. I wish to make it clear at the outset that I am testifying today on my own behalf and not as a representative of the Department of Health and Human Services. You asked me to appear today because I served as the Executive Director of the Commission on Nursing which reported to former Health and Human Services Secretary Otis R. Bowen. I am therefore here to discuss the nursing shortage and the work of the Commission, and not H.R. 1507.

After carefully examining the nursing shortage for more than a year, the Commission released its findings last December. We found that the reported shortage of RNs is real, widespread, and of significant magnitude. There is conclusive evidence that the nursing shortage cuts across all health care delivery settings and all nursing practice areas.

For instance, the evidence of shortages in hospitals--which employ 2/3 of all RNs--is extremely clear. RN vacancy rates have more than tripled between 1983 and 1987, and 76 percent of all hospitals report at least some degree of shortage. Hospitals in both urban and rural areas have been forced to close beds temporarily due to nurse shortages.

In addition, the current nurse shortage is exacerbating the chronic shortage of RNs in nursing homes. A 1987 survey suggests that the average nursing home vacancy rate is currently exceedingly high. Thirty-four percent of nursing homes reported "severe" RN shortages and 51 percent report that they required more than 90 days to recruit staff RNs.

This shortage persists despite the fact that the current supply of RNs is at an all-time high. Currently, there are over 2 million licensed RNs in the U.S., 31 percent more than in 1977. Eighty percent of all registered nurses are working in nursing and the unemployment rate among RNs is a record low of 1.2 percent. The registered nurse shortage is clearly a demand-driven shortage.

Based on the Commission's findings, I would like to mention some of the sections which would be most helpful in addressing the nurse shortage.

We found that the current shortage of RNs is primarily the result of an increase in demand, as opposed to a contraction of supply, at least in the short-term. More RNs (67.9%) are working in hospitals than at any other time in our history. In 1970, hospitals employed one RN for every four patients; in 1988, hospitals approached one RN for every patient.

This increase in demand is due to cost containment pressures, work compression, increasing severity of illness and an older population among hospital patients. The increased demand for RNs is also due to the change in medical practice patterns, advances in bio-medical technology, the spread of the HIV epidemic, a 14% increase in Intensive Care Unit beds, and decreasing hospital use of non-RN nursing personnel resulting in substitution of the RN for other workers.

The demand for nurses in other health care settings is also increasing. RN employment in Medicaid and Medicare certified nursing homes increased 22 percent from 1981 to 1986. From 1980 to 1987, Medicare home health visits provided by RNs increased almost 60 percent.

Mr. Chairman, I ask the committee to keep in mind that the implications of increased demand for nurses in a cost-containment environment means that nurses need to be utilized by employers in a far more efficient and effective manner. Furthermore, I would add that nursing services in the context of health care delivery need to be restructured in a more rational and efficient manner. They also need to be given essential support structures that will enable them to work more effectively and they must be willing to challenge every aspect of their activities as to the appropriateness to patient care outcomes.

Moreover, it was the finding of the Commission that foreign nurses should not be relied upon to significantly increase the domestic RN supply due to a number of factors:

- o The limited supply of qualified nurses in source countries;
- o U.S. immigration and foreign emigration restrictions;
- o Language barriers that have the potential of affecting perceptions about the quality of care given by these nurses; and
- o Difficulties experienced by these nurses in passing state RN licensure examinations.

Beyond these factors, the Commission also found that there are ethical considerations involved in recruiting nurses away from their home countries, which may themselves have serious health care needs. Furthermore, it is cited in the Commission's report that a reliance on nurses from abroad could discourage the domestic production of RNs.

Thus, it was the conclusion of the Commission that foreign nurses represent only a limited source of additional RNs and a short-term solution to the current shortage.

Employers of nurses can no longer use stop gap measures to deal with high RN vacancy and turnover rates. Rather, employers must concentrate on keeping nurses at the bedside by creating better working conditions through restructuring the work environment and redesigning the role and functions of the registered nurses within that environment.

Conclusion

Mr. Chairman, this is not a small problem that can be alleviated with a quick solution; it requires fundamental changes in the way in which our health care system currently functions.

Without changes, the shortage of RNs will affect the quality of patient care, access to health care, and the work environment for RNs. In a survey of nurses published by RN Magazine (October 88), it was reported that "Nine out of 10 respondents agree that the shortage is forcing them to provide care which they are less than personally satisfied, and four out of five tell us that patients are routinely at risk."

I thank you for this opportunity to appear, and I would be pleased to answer any questions which you may have concerning the findings of the Commission you may have.

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Mr. MORRISON. Next, Ms. Hatcher.

STATEMENT OF BARBARA J. HATCHER, M.P.H., R.N., AMERICAN NURSES ASSOCIATION

Ms. HATCHER. Mr. Chairman, I am Barbara J. Hatcher, director of nursing at the District of Columbia Commission on Social Services and the Mental Retardation Development Disability Administration and chairperson of the District of Columbia Board of Nursing.

The American Nurses Association and the Association of Operating Room Nurses appreciate the opportunity to address the nursing shortage and the recruitment of foreign nurses. ANA is also a labor organization representing 135,000 professional nurses.

The committee and Representative Schumer are to be commended for convening this hearing. A critical nursing shortage faces more than 75 percent of all the U.S. hospitals, despite the fact that almost 79 percent of all nurses are employed in nursing and 70 percent are employed in hospitals.

We are working with the hospital industry, labor organizations, and other health care providers, INS, and Congress to find solutions to this nursing shortage, including the use of foreign nurse graduates.

We support the valuable contribution foreign nurse graduates have made and worked to establish foreign graduate entry standards to ensure quality care. ANA helped found the Commission on Graduates of Foreign Nursing Schools in 1977. Before the CGFNS exam, only 15 percent of foreign nurses passed the licensing exam, the R.N. licensing exam specifically. Now, 89 percent of those who pass the CGFNS exam pass the R.N. licensing examination, which definitely shows the effectiveness of the CGFNS exam.

ANA is adamant that the licensure requirements for the H-1 classification continue to mandate the passage of the CGFNS exam or proof of State licensure before a nurse may engage in the practice of nursing.

In the last Congress, ANA worked with Representative Schumer to deal with the untimely expiration of many H-1 visas of foreign nurse graduates. The result was a 1-year legislative extension of H-1 visas for foreign nurses. A problem still exists, however, for nurses from countries which have backlogs of permanent residency applications. We view H.R. 1507 as a responsible legislative approach to address this ongoing dilemma.

We support the establishment of a new H-4 visa classification for foreign nurses with certain safeguards. We wholeheartedly endorse provisions requiring sponsoring hospitals to demonstrate that they are decreasing their reliance on foreign workers and taking steps to recruit and retain sufficient registered nurses, including the payment of wages above the prevailing wage rates for R.N.'s in those geographic areas that are impacted.

We believe that the INS-Booz-Allen study's assertion that the large presence of H-1 nurses could suggest that in the absence of these H-1 nurses the prevailing wage rate for nurses would rise to a higher level should be further evaluated.

We support the provision that requires H-1 visa nurses to be paid at the prevailing rate. Nursing is concerned about reports of exploitation by unscrupulous recruitment practices, burdensome expense paybacks, substandard housing, and inequitable salaries and work schedules. ANA would also like to see provisions to require facilities to demonstrate adequate training, supervision, and evaluation prior to and during the employment of H-1 visa nurses.

ANA supports the provisions restricting utilization of foreign nurses during labor negotiations. The collective bargaining process should be free from any employer action which hints of coercion. Nurses should not fear job displacement. We are aware that foreign nurses who are employed where strikes occurred in 1988 and who participated in the picket lines were intimidated by employers.

Although we support the intent of H.R. 2111, we believe a number of the provisions to be a duplication of measures already passed by Congress. We believe that section 7 in the bill will unfortunately repeat the past practice of INS, the provision of limitless extensions to H-1 visa holders.

The issue before the committee today centers on the use of appropriate visa classifications for foreign nurse graduates who wish to remain in the United States. We support a remedy to allow present H-1 visa nurses to pursue permanent residency. However, we agree with the Nursing Commission's conclusion that our health care delivery system should not rely upon foreign nurses as a long-range solution to the nursing shortage.

Changing immigration policy will not solve the nursing shortage, because the expanded importation of foreign nurses to work in U.S. hospitals does not address the root causes of the shortage which are primarily related to compensation and working conditions. We recommend the implementation of nursing strategies as identified by the Nursing Commission to solve the nursing shortage, and we further request administration support for funding of the Nurse Education Act.

We urge you to work with us towards the development and implementation of a lasting solution to the nursing shortage.

Thank you, Mr. Chairman.

Mr. MORRISON. Thank you very much.

[The prepared statement of Ms. Hatcher follows:]

AMERICAN NURSES' ASSOCIATION WASHINGTON, D.C.

TESTIMONY

OF THE

AMERICAN NURSES' ASSOCIATION

AND

ASSOCIATION OF OPERATING ROOM NURSES

BEFORE THE

IMMIGRATION, REFUGEES AND INTERNATIONAL LAW SUBCOMMITTEE

HOUSE JUDICIARY COMMITTEE

BY

BARBARA J. HATCHER, M.P.H., R.N., CNAA

MAY 31, 1989

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Mr. Chairman, I am Barbara J. Hatcher, M.P.H., R.N., CNAA, Director of Nursing at the Commission on Social Services in the Mental Retardation Development Disability Administration of the District of Columbia, and Chairperson of the District of Columbia Board of Nursing. I appear this morning on behalf of the 200,000 individual members of the American Nurses' Association (ANA) and its 53 constituent state nurses' associations. ANA is also a labor organization which represents over 135,000 professional nurses. ANA recognizes that if a high quality of nursing care is to be maintained, nurses must be assured professional self-determination and full participation in shaping the decisions that affect the conditions under which they practice. Substantial improvement in employment conditions is imperative to attract and retain sufficient numbers of well-qualified practitioners. Nurses perform a valuable service and should receive compensation commensurate with their responsibilities, preparation, and qualifications.

I am also representing the 40,000 members of the Association of Operating Room Nurses (AORN). We appreciate the opportunity to share with you our views on the nursing shortage and more specifically, to address pending legislation regarding the recruitment of foreign nurse graduates for employment in the United States. The committee, and particularly Representative Schumer, are to be commended for convening this hearing on an issue of such timely importance.

Mr. Chairman, all of us are aware of the fact that our nation is currently experiencing an acute shortage of registered nurses (RNs). According to the American Hospital Association, more than 75 per cent of all hospitals in the U.S. are experiencing such a shortage. One estimate predicts that more than 135,000 RNs are needed to fill existing vacancies in hospitals and nursing homes alone.

This problem has so jeopardized our nation's ability to adequately provide quality health care services, that former Health and Human Services Secretary Otis Bowen, M.D., convened a Secretarial Commission on Nursing in December 1987 to examine the causes of the shortage and to identify potential solutions. We are heartened at the extensive analysis that arose from the Commission's deliberations, and are working with the hospital industry as well as other health care providers on the implementation of the solutions recommended in the Commission's December 1988 report. As part of its analysis of the nursing shortage, the Commission carefully examined and deliberated the use of foreign nurse graduates to meet nurse staffing demands.

The ANA is aware of, and supportive of, the valuable contribution foreign nurse graduates have made to our nation's health care delivery system. Historically, ANA has supported the efforts of foreign nurses who wish to seek employment in the United States, while working to ensure quality care for those who need health care. In recognition of the problems encountered by foreign nurses who pursue employment in the U.S. as nurses, ANA has pushed for established foreign graduate entry standards, equitable treatment, and wage protections for all nurses. In addition, ANA helped found the Commission on Graduates of Foreign Nursing Schools (CGFNS) in 1977, in response to the Immigration and Naturalization Service (INS) and Department of Labor (DOL) review of the Department of Health, Education, and Welfare's development of a plan for evaluation of foreign nurse credentials.

BACKGROUND

Over a decade ago, ANA joined the Department of Health and Human Services in addressing the utilization of foreign nurse graduates. At that time, the issue

was quality assurance and licensure. In the years immediately preceding the establishment of CGFNS (from 1969 to 1978), approximately 82,000 foreign nurses were admitted to the U.S., but only about 15 percent passed the licensing exam. When the other 85 percent could not be licensed to practice as registered nurses in the U.S., some were forced to leave the U.S. reportedly feeling discriminated against, and others were placed in low paying, non-professional jobs in this country.

From 1978 through 1986, 63,868 foreign-educated nurses have applied to take the CGFNS exam. Of that number, 55,555 were found qualified to take the exam, and 25,466 or 45.8 percent, educated at nursing schools in 98 countries, have passed the exam and received the CGFNS Certificate. Of the known CGFNS Certificate Holders in the U.S., approximately 89.2 percent have taken and passed the registered nurse licensing exam in the U.S., and hold a nursing license as a registered nurse in this country. This 89 percent pass rate can be favorably compared to the less than 15 percent pass rate that prevailed before CGFNS. The effectiveness of the CGFNS exam, in screening foreign nurses who are qualified to become registered nurses in this country, has been recognized by the U.S. Government, as well as a large number of state governments.

We recognize that recruitment of foreign nurses has intensified during this severest of nursing shortages. CGFNS has had to keep pace with the nurse shortage. A record 20,000 CGFNS exams were administered in 1988, growing from 12,000 in 1985; 14,000 in 1986; and 18,000 in 1987.

Last year, national attention focused on the foreign nurse graduate who was employed under the aegis of the H-1 Visa. In September 1985, the INS issued an interim policy warning H-1 Visa grantees that they must apply for permanent

status or leave the U.S., because the five year residency period would be enforced as of April 1987. Unfortunately, some foreign nurses, or more accurately their employers, neglected to file for conversion to permanent status or for the additional year which the INS may allow in extraordinary circumstances. In some instances, therefore, it was an oversight by employers which led to this situation.

The problem was compounded because a significant number of nurses who hold H-1 Visas are from the Philippines. Quotas for permanent residency are such that Philippine nationals must wait seven to 14 years, because of backlogs, to convert to permanent status. Additionally, before the INS's 1985 compliance directive, many H-1 Visa holders had been given endless extensions by regional INS offices. Therefore, enforcement of the five year period meant that nurses who had been here for 10 to 15 years were faced with deportation. Reportedly, a number of these nurses had been dissuaded from applying for their permanent residency because of the backlogs. Therefore, they have been disadvantaged by their reliance on direction from employers, immigration officials and advisers, and this new active enforcement of INS policies.

Over the last year, the ANA has worked with the INS and Congress to allow these affected nurses an additional year to apply for permanent alien status. As a valuable cadre of skilled nurses, the ANA has no desire to see these nurses deported from the country. Subsequent to meetings with the INS, the affected nurses were granted an additional year's extension if their employers applied on a case-by-case basis. While INS was not willing to simply grant a blanket extension, it was willing to help those nurses who would be adversely affected by the law. It is important to note that the INS does not see changes in immigration policy as the solution to the nursing shortage, but rather that

employers must pay higher salaries to U.S. nurses in order to address the problem.

While the agency efforts were under way, several legislators also proposed ways to cure the problem. ANA worked closely with Representative Schumer to provide temporary relief from the threat of deportation for expired H-1 Visa holders. The result was a legislative extension of H-1 visas for certain foreign nurse graduates for one year. However, that only solved part of the dilemma. A problem still exists for those nurses from countries which have backlogs of permanent residency applications. That extra year will not provide an opportunity for conversion to permanent residency.

H.R. 1507, "The Immigration Nursing Relief Act of 1989"

As you know, it was the untimely expiration of many H-1 Visas of foreign nurse graduates in certain localities that prompted the enactment of P.L. 100-658. The ANA was fully supportive of this effort to preserve the nurse staffing integrity of affected hospitals as well as other health care facilities. We view H.R. 1507 as a responsible approach to address this ongoing dilemma, and we are working with Representative Schumer and the committee towards its enactment into law.

The issue before the committee today centers not on the value or qualifications of these practitioners, but rather upon the use of appropriate visa classifications for them. While ANA supports a remedy to allow those present H-1 Visa nurses to remain in the United States, we do not encourage this committee to view the use of foreign nurses as a solution to the current shortage. While the use of foreign labor would represent a legitimate short-term

strategy to ease a temporary shortage, it has become clear that the current shortage of RNs is not temporary, and that the real solutions to the problem lie far beyond securing foreign labor. The ANA is in complete agreement with the Nursing Commission, whose report concluded that our health care delivery system should not rely upon foreign nurses as a long-range solution to the nursing shortage. Several factors led the Commission to this conclusion, including: the limited supply of qualified nurses in source countries; existing U.S. immigration policies that restrict foreign emigration; difficulties experienced by foreign nurses in passing state RN licensing examinations; and significantly, that the accelerated recruitment of foreign nurse graduates by U.S. employers has the potential of prompting a "brain drain" of highly trained health care practitioners upon whose skills and talents their parent countries heavily rely.

Other provisions of H.R. 1507 provide for the establishment of a new "H-4" Visa classification to replace the use of the H-1 Visa for foreign nurses. The creation of a separate category for this immigrant population would allow the Immigration and Naturalization Service to be better able to monitor and regulate the foreign nurse population. Before granting the H-4 classification, sponsoring employers of foreign nurses must demonstrate to the satisfaction of the Secretary of Labor that the employer has taken significant steps to recruit and retain U.S. nurses. This provision would require sponsoring hospitals to demonstrate that they are decreasing their reliance on foreign workers. The bill outlines several criteria for demonstrating that the employing facility is taking significant steps designed to recruit and retain sufficient registered nurses from local labor pools, including the payment of wages at a rate above the prevailing wage rate for RNs in that geographic area. We believe that the incorporation of safeguards such as this will prevent the misuse of the proposed H-4 Visa.

ANA is pleased that the bill provides for the H-1 Visa nurse to be paid at the prevailing rate. We are concerned about reports from state nurses' associations that foreign nurses may be exploited by unscrupulous recruitment practices which require burdensome expense paybacks, place nurses in substandard housing, and provide inequitable salaries and work schedules.

ANA would like to see additional criteria included in Section (3)(b)(2)(A). We believe that the facility must demonstrate that it provides adequate training, supervision and evaluation prior to, and during, the employment of H-1 Visa nurses. Some nurses have expressed concern that they did not receive sufficient orientation to nursing units, patient care procedures, hospital procedures and technology which may differ from their experience.

ANA believes that H-1 visa nurses must be assured non-exploitative employment, as well as equitable wages and working conditions. Those protections also assure fair working conditions for nurses who are United States citizens. ANA is working with the Commission on Graduates of Foreign Nursing Schools, nurse recruiters and other nursing organizations, to ensure appropriate utilization of foreign nurses and effective administration of licensure and quality assurance mechanisms.

H.R. 2111. "The Emergency Nurse Shortage Relief Act of 1989"

ANA supports the intent of Representative Ackerman's legislative proposal. However, we believe a number of the provisions to be duplicative of measures already passed by Congress in the reauthorization of the Nurse Education Act (P.L. 100-658).

We believe that Section 7 in H.R. 2111 will unfortunately repeat the past practice of the INS, the provision of limitless extensions to H-1 Visa holders. Such an approach does not solve the Filipino nurses' dilemma of timely conversion to permanent status. Additionally, we must stress that it also reinforces the misuse of the H-1 Visa, which is supposed to be a temporary visa.

RESPONSE TO INS ACTION

Last fall ANA responded to the INS proposed regulations regarding classification of temporary alien workers. At that time we also reviewed an INS commissioned study, conducted by Booz-Allen & Hamilton, Inc. Management Consultants, which established that nurses account for the second largest occupational group of H-1 Visa admissions. ANA is, therefore, interested in the promulgation of this and any subsequent rulemaking which rely on the findings or recommendations of the Booz-Allen study.

ANA encourages the INS to continue to emphasize the temporariness of H-1 alien workers. We agree with the observations of the study, as cited in the preamble of the proposal, that workers are primarily sought under H-1 admissions to meet labor shortages of American workers. However, we do not believe the study substantiates its assertion that H-1 non-immigrants do not have an adverse impact on the labor market in terms of depression of wages and working conditions. ANA believes it is imperative to further evaluate the study's assertion that:

“Nonetheless, the large presence of H-1 nurses in the New York City labor market area could suggest that in the absence of these H-1 nurses, the prevailing wage rate for nurses would rise to a higher level. The withdrawal of several thousand nurses, perhaps as many as 20 percent or more

of those employed, could conceivably force wages to a higher level in order to attract the supply of nurses required by New York City area employers. We are not able to fully evaluate this possibility based on the data available to us."

In our written response to the rulemaking, ANA supported the clarification regarding criteria determination for H-1 classification of aliens. We wholeheartedly endorsed the inclusion of the definition of "profession" as criteria for distinguished merit and ability. At this time we believe it is important to have flexible, alternative ways by which a person may qualify as a member of the profession, because a registered nurse can graduate from a baccalaureate, diploma or associate degree program.

ANA is adamant that the licensure requirements for H-1 classification continue to mandate the passage of the Commission on Graduates of Foreign Nursing Schools examination or proof of state licensure before a nurse may engage in the practice of nursing. ANA does have questions regarding the requirement, under Section (D) H-1 petitions for professional nurses (1) Beneficiary requirements, which states a nurse must have obtained a full and unrestricted license of practice in the state of intended employment. It is our understanding that some states issue a temporary license to specific foreign nurse graduates and we believe that would be a restrictive license.

We agree with the limitation on approval of an H petition where licensure is required and the necessary licensure has not been attained. Such a restriction will help prevent abuses of the system and ensures qualified nurses for the U.S. public.

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ANA is concerned that the INS has not clarified the utilization of H-2B classifications as adamantly for nurses as it does for graduates of medical schools. We believe the limitation of the H-2B classification to the non-agricultural temporary worker to perform temporary services or labor should not be available for nurses, notwithstanding the inability to find U.S. workers capable of such services or labor. We do not believe that temporary services or labor as defined in the proposal applies to health care services, as data indicates that duties attendant to those services will escalate and therefore the employers' needs are not temporary.

We applaud the inclusion of language requiring that the terms of employment for non-immigrant workers be included with an H-1 petition. ANA has received many anecdotal reports of questionable foreign nurse recruitment practices and inequitable working conditions for foreign nurses.

ANA supports the provisions of Section (h)(16) which limit approval of H petitions when a strike or labor dispute is in progress. We believe that the rights of nurses to the collective bargaining process should be free from any employer action which could hint of coercion. United States nurses should be able to exercise their collective bargaining rights without the fear of job displacement. ANA is also concerned because we are aware that foreign nurses employed in hospitals where strikes occurred in 1988, and who participated in picket lines, were intimidated by employers. ANA believes that provisions of Section (h)(14) which address extension of stay are a necessary clarification regarding the temporariness of H-1 visas.

CONCLUSION

Mr. Chairman, ANA and AORN support the efforts of foreign nurses who wish to remain in the United States to appropriately pursue permanent residency status. However, we view the recruitment of foreign nurses as only one short-term strategy in dealing with the nursing shortage. Changing immigration policy will not solve the nursing shortage, because the expanded importation of foreign nurses to work in U.S. hospitals does not address the root causes of the shortage, which are primarily related to compensation and working conditions. ANA has identified the following as nursing strategies to solve the nursing shortage:

1. The positive aspects of nursing need to be emphasized to other health care providers and to the public so that the "image" of nursing improves. This improved image, or clarity about nursing's identity, will help to make nursing a more attractive career option for both young women and men in the future.
2. Hospitals must free nurses from performing non-nursing functions by making more efficient use of existing personnel such as clerical help, transportation assistance, and dietary aides. Also, computers and other technological support in patient care areas save time and enhance efficiency.
3. Financial and workplace incentives need to be implemented to encourage nurses working part-time to return to full-time employment. Flexible scheduling, innovative and flexible benefit packages, promotion, and financial incentive systems that recognize clinical excellence and productivity, can be offered to attract part-time nurses into full-time employment.
4. Studies show that in order to retain more nurses in nursing, salaries must,

at a minimum, increase over time after adjusting for inflation. Better lifetime career earning patterns are needed in nursing to eliminate serious salary compression and to make nursing more competitive with other professions.

5. Studies also indicate that retention of nurses in the profession increases when nurses have greater professional autonomy and play a greater role in decision-making in hospitals.
6. Maximizing educational opportunities and making financial support available to prospective nursing students are key elements in successful nursing recruitment. Nursing educational outreach programs that recruit people with a health care background can be effective in quickly expanding the overall pool of nurses, particularly if financial aid is available to qualified persons working to complete accelerated nursing education programs.
7. Because nursing is a vital public resource, state and federal governments must continue to invest in the profession. Adequately funding the federal Nurse Education Act, providing direct payment of registered nurses under government health programs like Medicare, and opposing cutbacks in funding for health programs, can affect both the recruitment and retention of nurses.
8. Efforts should be devoted to educating the public about what they can expect from nurses and how nurses are educated to function effectively in today's complex health care system. This education also needs to increase public awareness about the broad range of services, such as clinical management and case management, that nurses provide for the consumer's health care dollar. Persons who are educated about nursing are more likely to recognize the value of the profession.

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ANA and AORN will continue to work with the health care industry and Congress to assure quality care for patients, equitable treatment of foreign nurses, the preservation of career positions and opportunities for United States nurses, and maintenance of professional standards which guide the admission of foreign nurses into the United States workforce.

We urge the Congress to work with professional nursing, as well as other members of the health care community, to look beyond temporary solutions and work towards the development and implementation of a lasting solution to this problem. Thank you the opportunity to address immigration policies and their impact on the nursing shortage.

Mr. MORRISON. Ms. Lowery.

STATEMENT OF FILIPINAS LOWERY, FILIPINO NURSES ASSOCIATION

Ms. LOWERY. Mr. Chairman and distinguished members of the committee, good morning. Good afternoon, I should say.

I am Filipinas Lowery, president of the Philippine Nurses Association of America and currently director of perioperative services at the Brookdale Hospital Medical Center in Brooklyn, NY. The Philippine Nurses Association of America and its constituent member organizations across the Nation thanks you for the privilege and opportunity to testify at this important hearing on the proposed bills, H.R. 1507 and H.R. 2111.

Our association appreciates the leadership of Congressman Schumer and the other distinguished sponsors of H.R. 1507 in seeking a more permanent resolution of the problems created by restrictions on the duration of H-1 visas for foreign nurses. Equally commendable are Congressman Ackerman and the cosponsors of H.R. 2111 for their efforts to assure the establishment of programs to increase the supply of professional nurses through more aggressive funding for nurse recruitment, retention, and education. Their obvious interest and commitment towards alleviating the acute nursing shortage is gratifying, and we appreciate the opportunity to comment on their proposed bills.

The acute nursing shortage has reached critical levels with no quick solutions in sight. This dilemma is further compounded by the increasing demand for health care by a clientele that is aging, afflicted with chronic, multisystem illness, a rapidly escalating number of AIDS victims, all requiring highly technical modes of treatment in the face of pressures to contain health care costs.

The nursing shortage is particularly critical in urban centers, such as New York and New Jersey, where the vacancy rate ranges from 15 to 25 percent. The high incidence of AIDS in the New York City area has necessitated the opening of more hospital beds. The graph on page 2 shows the percentage; 22 percent of the total AIDS victims in the United States are in New York City.

The decline in enrollment of students in schools of nursing in the United States makes the prospect even dimmer for increasing the pool of nurses. The attached table of nurses licensed from 1983 to 1989 reflects a decline of 23.7 percent in U.S. educated nurses from 1986 to 1988. The table also shows 32,388 foreign nurse graduates licensed for that same period, 8,278 of whom are from the Philippines. Foreign educated nurses licensed during this period constitute 6.7 percent.

With the increasing shortage of professional nurses, hospitals and nursing homes, particularly in urban areas, have attempted to increase their pool of nurses by recruiting foreign educated nurses. Qualified foreign nurses have been allowed to enter the United States on the basis of distinguished merit and ability under the nonimmigrant H-1 visa classifications. However, the Immigration and Naturalization Service instituted a 5-year limit on H-1 visas, as stipulated in regulation 8 CFR 214.2(H) effective March 1987.

The imposition of a 5-year limit on H-1 visas posed a serious threat to the retention of thousands of qualified, experienced foreign nurses. Their departure would further aggravate the nursing shortage, paralyze hospital operations, and jeopardize the quality of health care.

In response to a petition from 42 legislators, INS granted a 1-year extension beyond 5 years on May 26, 1988. Representative Schumer introduced a bill in September 1988, which was revised, and allowed a 1-year extension up to December 1989, after which we will be faced once again with the problem of retaining nurses whose H-1 visas have expired unless a permanent solution will be resolved.

I have a table which shows statistics of H-1 nurses in the New York City area and in New Jersey. In the New York City and New Jersey area, there is a total of 5,301 foreign nurses who arrived between—before 1985 to 1989. This represents a total of 51 hospitals and nursing homes out of 121 from the New York City area and 81 out of 110 from the New Jersey area.

As you can see, the total number of H-1 nurses in these areas whose visas will expire by December 1989 is 1,645, and in 1985 another 1,130. Obviously, this does not represent all the H-1 nurses, since not all the hospitals have responded at this time. A large majority of these nurses have applied for permanent status but are subject to the backlog on the third preference to January 22, 1973, and to January 8, 1985, for the sixth preference.

In view of the nursing crisis across the Nation, the loss of almost 1,500 nurses and another 1,000 in 1990 will have tremendous impact on the 15- to 20-percent vacancy rate and result in hardship. The possibility of replacing these nurses immediately by U.S. educated nurses is slim. Besides, the cost for replacement is prohibitive. The national average cost per hire is \$1,163 and ranges up to \$9,000. This is a survey conducted by Nursing 1989 for the National Association of Health Care Recruitment. Based on the above figures, the average cost to fill 2,500 vacancies will be \$5,415,000 and could go as high as \$12,500,000.

The proposed granting of special immigrant status to those nurses with valid H-1 visas who entered the United States before January 1, 1989, will certainly obviate the drastic reduction of the nursing pool and consequent disruption of health care services. As pointed out before, replacement costs do not include orientation costs of approximately \$10,000 per nurse.

Our association requests that consideration be given to set the cutoff for granting special immigrant status to the effectivity date of this bill provided the nurses pass the licensing examination for professional nurses. Based on statistics presented, approximately 1,000 more nurses arrived after January 1, 1988, in the New York and New Jersey area alone. Retention of these nurses in the nursing pool will certainly help the nursing shortage.

We also request that licensed out-of-status nurses hired prior to November 1986 who have not been granted extension of their H-1 visas since these may have expired prior to the moratorium—the extension last year but are awaiting issuance of permanent immigrant status be included among those to be granted special immigrant status.

The blanket labor certification as required in H.R. 1507—as required in the H-1 visa petition should also apply in the implementation of H.R. 1507. The proposal to establish a new immigrant—nonimmigrant classification for foreign nurses and the requirement to be fulfilled by both the nurse applicant and the employer are reasonable and we feel are necessary to improve working conditions, utilization, and salary of nurses.

However, in light of current nursing shortage, imposing these changes in classification and requirements for future admission which appear to be more stringent than the currently required to obtain H-1 visas might lengthen the approval process. Granting special immigrant status to certain H-1 nurses will only assure the retention of these qualified nurses but will not enlarge the pool, so we have to be able to recruit additional nurses to fill the vacancies.

Our association would like to see sections 1 and 2 of H.R. 1507 enacted with some revisions as stated, but we would like to recommend that a blanket approval be granted to institutions for a given period of time based on fulfillment of the requirements as stipulated with a periodic review.

On the H.R. 2111, we would prefer a more long-term solution in terms of the extension of the H-1 visa, as was proposed in H.R. 1507.

Again, thank you very much for the privilege of testifying before this committee.

Mr. MORRISON. Thank you very much.

[The prepared statement of Ms. Lowery follows:]

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TESTIMONY

ON

H.R. 1507

"IMMIGRATION NURSING RELIEF ACT 1989"

AND

H.R. 2111

"EMERGENCY NURSE SHORTAGE RELIEF ACT OF 1989"

PRESENTED BY

THE PHILIPPINE NURSES ASSOCIATION OF AMERICA

BEFORE

THE U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON THE JUDICIARY
SUBCOMMITTEE ON IMMIGRATION, REFUGEES
AND INTERNATIONAL LAW

MAY 31, 1989

Chairman of the House Committee on the Judiciary, Hon. Jack Brooks, chairman of the Subcommittee on Immigrations, Refugees and International Law, Hon. Bruce Morrison, distinguished committee members and legislators, colleagues, ladies and gentlemen, good morning. The Philippine Nurses Association of America and its constituent member organizations across the nation thanks you for the privilege to be represented and opportunity to testify at this important hearing of the Subcommittee on Immigrations, Refugees and International Law concerning the proposed bills: H.R. 1507, "Immigration Nursing Relief Act of 1989" and H.R. 2111, "Emergency Nurse Shortage Relief Act of 1989".

Our Association represents 15 constituent organizations across the United States, comprised of Philippine nurses who are U.S. citizens, permanent residents and H-1 visa holders. The main thrust of the Association is to unite all Filipino nurses and provide a mechanism for networking towards enriching knowledge and skills; promoting professional excellence; providing resource and support to new arrivals; articulating concerns and resolving problems that affect Filipino nurses; and collaborating with organized nursing and other health care organizations to address mutual concerns that impact nursing and health care delivery.

As an integral part of the whole nursing collective and as Philippine nurses in particular, our Association appreciates the leadership of Congressman Charles Schumer and the other distinguished legislators who sponsored H.R. 1507 in seeking a more permanent resolution of the problems created by restrictions on the duration of H-1 visas for foreign nurses. Equally commendable are Congressman Ackerman and the co-sponsors of H.R. 2111 for their efforts to assure the establishment of programs to increase the supply of professional nurses through more aggressive funding of nurse recruitment, retention and educational programs. Their obvious interest and commitment towards alleviating the acute nursing shortage is gratifying and we appreciate the opportunity to comment on their proposed bills.

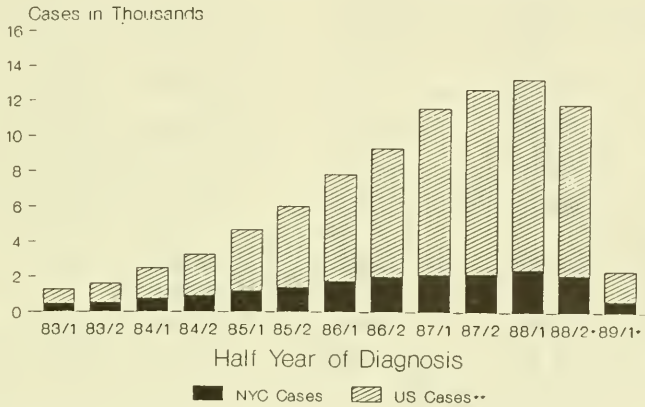
BACKGROUND:

The acute nursing shortage has reached critical levels with no quick solutions in sight. This dilemma is further compounded by the increasing demand for health care by a clientele that is aging and afflicted with chronic multi-system illness, a rapidly escalating number of AIDS victims, all requiring highly technological modes of treatment in the face of pressures to contain health care costs. The location where health care is delivered has also shifted to the community, thus making hospitals acute care institutions. The nursing shortage is particularly critical in urban centers such as New York and New Jersey where the vacancy rate ranges from 15 - 20%. The high incidence of AIDS in the New York City Area has necessitated the opening of more hospital beds. The Center

for Disease Control surveillance report dated March 31, 1989 shows that out of the total 50,990 reported AIDS victims in the United States, 22% are in New York City.

AIDS INCIDENCE 1983-1989

New York City and United States



* Preliminary data as of 4/89

** U.S. data as of 3/31/89

The decline in enrollment of students in schools of nursing in the United States makes the prospect even dimmer for increasing the pool of nurses. The attached table of nurses licensed from 1983 to 1989 reflects a decline of 23.7% in U.S. educated nurses between 1986 and 1988. The table also shows 32,588 foreign educated nurses licensed for the same period, 8,278 of whom are from the Philippines. Foreign educated nurses constitute 6.7% of the total number of nurses who passed the professional nurse licensing examination for that period.

NUMBER OF NURSES WHO PASSED R.N. LICENSING EXAMINATION
1983-1989

<u>YEAR</u>	<u>U.S. EDUCATED</u>	<u>FOREIGN EDUCATED</u>	<u>TOTAL</u>	<u>PHILIPPINE NURSES*</u>
1983	62,633	4,591	67,224	1,400
1984	78,767	5,837	84,604	1,825
1985	80,920	3,420	84,604	812
1986	79,761	5,435	85,196	1,270
1987	71,854	4,412	76,266	1,014
1988	60,879	5,243	66,122	1,088
1989 (FEB)	18,030	3,650	21,680	869
TOTAL	452,844	32,588	485,432	8,278
	93.3%	6.7%		

SOURCE: National Council of State Boards of Nursing

*Included in total foreign educated nurses

The inadequate supply of nurses to meet the increasing demands for health care creates an imbalance in the work situation wherein the workload has to be shouldered by the existing staff. This creates significant stress, frustration and eventually, burnout. Nurses leave their chosen field because they cannot practice with any sense of professionalism and the monetary rewards are not commensurate with the hard work, long and unholy hours that they put in. Lack of support staff to perform non-clinical functions plus the inordinate amount of paperwork to meet regulatory standards takes them further away from the patient's bedside. This vicious cycle creates difficulties in the retention of qualified nurses within the work force.

With the increasing shortage of professional nurses, hospitals and nursing homes particularly in urban centers have attempted to increase their pool of nurses by recruiting foreign educated nurses over the past ten years. Qualified foreign nurses have been allowed to enter the United States on the basis of "distinguished merit and ability" under the non-immigrant H-1 visa classification. At present, nurses belong to schedule "A", thereby exempting them from filing individual applications for labor certification to support a petition for H-1 status or permanent residency. There are no limits to the number of H-1 admissions. Although they were initially admitted for only two or three years, many nurses and other professionals under this H-1 classification had been allowed to extend their visas every year for several years. However, the Immigration and Naturalization Service instituted a five-year limit on H-1 visas as stipulated in Regulation 8 CFR 214.2(H), effective March, 1987.

The imposition of a five-year limit on H-1 visas posed a serious threat to the retention of thousands of qualified experienced nurses. Their departure would further aggravate the nursing shortage, paralyze hospital operations and jeopardize the quality of health care. Since there is a large concentration of H-1 nurses in the New York and New Jersey metropolitan areas, the hospitals and nursing homes located there would have been jeopardized. However, INS granted a one-year extension to the five years on May 26, 1988. Representative Schumer introduced a bill in September, 1988, proposing to grant special immigrant status to foreign nurses with valid H-1 visas who arrived prior to January 1, 1988 but its provisions were changed to allow a one year extension up to December 31, 1989, after which we will be faced again with the problem of retaining nurses whose H-1 visas have expired. The following table shows the numbers involved.

	<u>Date of Arrival: No. of Nurses</u>						<u>No. Hosp. Homes</u>
	<u>Before 1/1/85</u>	<u>1985</u>	<u>1986</u>	<u>1987</u>	<u>1988</u>	<u>1989</u>	
New York City	1,158	515	433	544	770	231	3,661 51
New Jersey	487	615	(Not available)				1,640 81
Total	1,645	1,130					5,301 132

85 % of the H-1 nurses in New York City and 92% in New Jersey are from the Philippines. These statistics were obtained from the NYC Health and Hospital Corporation, Greater New York Hospital Corporation and the Hospital Association of New Jersey. An attempt was made to obtain data from other major metropolitan areas but this was not readily available although a number of the hospitals and homes admitted that they employ H-1 nurses. A large majority of these nurses have applied for permanent status but are subject to the backlog in the third preference dating back to January 22, 1973 and to January 8, 1985 for sixth preference for Philippine nationals, since the 20,000 annual quota is over-subscribed. Their H-1 visas will expire long before they are granted permanent status. Nurses from other countries do not have to wait as long but the largest pool of qualified nurses are from the Philippines.

In view of the staffing crisis across the nation, especially in urban areas such as New York and New Jersey where the bed occupancy remains extremely high, the loss of almost 1,500 nurses after December 31, 1989 plus about 1,000 in 1990 will have a tremendous impact on the 15 - 20% vacancy rate and result in significant hardship in maintaining effective health care delivery. The possibility of replacing these nurses immediately by U.S. educated nurses is slim and the supply of qualified foreign educated nurses who have satisfactorily passed the qualifying examination administered by the Commission on Graduates of Foreign Nursing Schools are now being shared by other areas that have just started foreign recruitment.

Assuming that there is sufficient supply of nurses to readily fill the vacancies created by the nurses whose H-1 visas have expired, the cost to replace them is prohibitive. In a recent survey conducted by Nursing '89 in conjunction with the National Association of Health Care Recruitment, the national average cost per hire is \$1,163 and ranges up to \$9,000. The cost per hire in the various regions vary as follows:

<u>Region</u>	<u>Average Cost Per Hire</u>	<u>Range</u>
Northeast	\$ 2,166	\$ 75 - 5,000
South	1,769	466 - 5,000
North Central	1,881	65 - 9,000
West	2,045	164 - 8,000

Based on the above figures, the average cost to fill 2,500 vacancies will be \$5,415,000 and expenditures could go as high as \$ 12,500,000.

The foregoing background information will have to be seriously considered in analyzing the implications of the proposed bills that are being discussed at this hearing.

H.R. 1507: "IMMIGRATION NURSING RELIEF ACT OF 1989"SECTION 2. SPECIAL IMMIGRANT STATUS FOR CERTAIN H-1 NON-IMMIGRANT NURSES.

The proposed granting of special immigrant status to those nurses with valid H-1 visas who entered the United States before January 1, 1989, including those whose visas were extended under Section 4 of the Immigration Amendments of 1988 and who are employed as registered nurses as of the date of enactment of the bill, will certainly obviate the drastic reduction of the nursing pool and consequent disruption of health care services. Replacement costs have been cited previously to which will be added expenditures for orientation of approximately \$10,000 per nurse.

CUT-OFF:-Our Association requests that consideration be given to set the cut-off to the date this bill is enacted instead of January 1, 1988, provided that the nurse has passed the licensing examination for professional nurses. Based on the statistics presented, approximately 1,000 nurses arrived on or after January 1, 1988 in the New York and New Jersey area alone. The retention of these nurses in the nursing pool will certainly help alleviate the nursing shortage.

INCLUSION OF LICENSED OUT OF STATUS NURSES:- We request that licensed out of status nurses hired prior to November, 1986, who have not been granted extension of their H-1 visas, but are awaiting issuance of permanent immigrant status be included among those to be granted special immigrant status. There is a significant number of fully licensed and experienced nurses who have exceeded the allowed time frame for H-1 visas, including recent extensions, but have approved immigrant visa petitions and are just caught up in the backlog for sixth or third preference. Again this retention of these nurses will maintain the nursing pool.

LABOR CERTIFICATION:- The blanket labor certification for Schedule "A" professionals such as nurses which has been employed in obtaining H-1 visa petition should be used to fulfil this requirement. The labor certification which is based on previously proven need for persons with "distinguished merit and ability" should still be valid as long as the individual continues to work as a professional nurse.

SECTION 3. REQUIREMENTS FOR ADMISSION OF NON-IMMIGRANT NURSES DURING A FIVE YEAR PERIOD.

The proposal to establish a new non-immigrant classification for non-immigrant nurses and the requirements to be fulfilled by both the nurse applicant and the employer seem reasonable and fair. However, in light of an unresolved nursing shortage,

imposing these changes in classification and requirements for future admission of non-immigrant nurses which appear to be more stringent than what is currently required to obtain H-1 visa might lengthen the approval process. Granting special immigrant status to certain H-1 nurses as proposed in Section 2 will not increase the nursing pool but will assure the retention of qualified nurses who are now an integral part of the existing professional nursing pool. The 15 - 20% vacancy rate will persist and possibly worsen until such time that efforts to recruit and retain U.S. nurses, as well as provide adequate support services will bear fruit.

We offer the following comments and urge that they be seriously considered in terms of maintaining and/or increasing the pool of qualified professional nurses in a timely and expeditious manner.

- Health care facilities will no longer be able to employ the relatively simple procedure for petitioning nurses under the current H-1 visa provisions. Registered nurses, regardless of "distinguished merit or ability" will not be able to gain entry into the U.S. on an H-1 visa as other professionals in this classification.
- Health care facilities will have to obtain individual certification from the Department of Labor, attesting to the following:
 - Substantial disruption of health services without the alien.
 - Alien's employment will not adversely affect the wages and working conditions of similarly employed nurses.
 - Significant recruitment and retention efforts demonstrated by the institution
 - No strike or lockout
 - Providing the bargaining representative notice of filing or posting notice where there is no bargaining unit

Although the bill proposes automatic labor certification for urban areas where nursing shortage exists, individual certifications are required for the other requirements which will be subjected to case by case examination. This could be a cumbersome and time consuming process and leaves plenty of room for varied interpretation by individuals examining the extent to which these criteria are met.

- The underlying concern that foreign nurse recruitment might affect the economic position of American workers has been negated by the recent Booz-Allen study underwritten by the INS at the request of Congress.
- Imposing multiple certification criteria in filing petition H-5 visa is likely to create additional hardship in recruit-

ment of foreign nurses and possibly result adversarial intervention by bargaining agents on labor issues.

The need to increase and maintain the pool of qualified foreign nurses is crucial until such time that outcomes from strategies to resolve the nursing shortage, such as those proposed in H.R. 2111, are fully realized. The recruitment and retention of foreign nurses is the fastest and most cost effective measure, at this time, to enlarge the pool of qualified nurses and maintain safe levels of staffing while measures to relieve the nursing shortage are being implemented.

H.R. 2111: "EMERGENCY NURSE SHORTAGE RELIEF ACT OF 1989"

Our Association congratulates the sponsors of this proposed bill which appears to be quite comprehensive and extensive in scope. It covers provisions for funding of programs to:

- o Retain practicing nurses through innovative restructuring of roles, working conditions, wages and benefits and by providing for career advancement.
- o Encourage entrants to the profession by increasing access to basic nursing education.
- o Provide for graduate nursing education
- o Provide for scholarships for basic and advance nursing education

SEC. 7. EXTENSION OF H-1 VISAS FOR REGISTERED NURSES IN NURSING CRISIS AREAS.

The implication that employment of H-1 visa nurses might adversely affect wages and working conditions of registered nurses in the United States need not be a matter of concern in view of the small percentage of licensed foreign educated nurses (6.7%) as previously cited. This number is not significant enough to affect wages and working conditions, but rather will enhance staffing and the effective practice of nursing. Therefore, extensions on the H-1 visa for as long as there is a staffing shortage.

SEC. 8. DESIGNATION OF NURSING CRISIS AREAS AND AREAS OF SPECIALIZED NURSING SKILLS.

Consideration should be given to clearly define what constitutes specialized nursing skills, including the level of education required. We urge that reimbursement structures for nurse practitioners be re-examined in light of increasing demands for expertise.

Once again, the Association reiterates its appreciation for the privilege to present our comments on the proposed bills and will be very glad to participate and be of service whenever the need arises. We hope that our comments have been helpful and that our recommendations be considered.

Mr. MORRISON. Ms. Stewart.

STATEMENT OF RUTH STEWART, R.N., SCHOOL OF NURSING,
UNIVERSITY OF TEXAS

Ms. STEWART. Mr. Chairman and members, I am Ruth Stewart, registered nurse and associate professor at the University of Texas School of Nursing in San Antonio. I am past president of the Texas Nurses Association. I appreciate this opportunity to comment on H.R. 1507 and H.R. 2111. I am gravely concerned with the crisis resulting from the inadequate numbers of nurses to meet our national health care needs. I appreciate the efforts of Congress to address the problems.

H.R. 1507 does provide partial and temporary help in allowing foreign nurse graduates with H-1 visas to become special immigrants and to continue to contribute to nursing. These nurses are currently licensed and surely have learned something about our culture and legal operations necessary to safe, effective nursing care. The initial high cost of recruiting, relocating, and orienting them has already been invested. Allowing them to continue to practice nursing is preferable to replacing them with a new wave of foreign nurse graduates.

Development of a system to ensure meeting our national needs for nurse power is critical. Continued reliance on foreign nurse graduates is unconscionable. The provisions of section 3 of the bill do provide controlled conditions under which institutions can recruit foreign nurse graduates, which is helpful. The basic problem is more complex, as you have been hearing.

The issue of attaining and retaining nurses in the health care system is not new. A study in my State in 1951 was titled "Texas Nursing in Review: A Crisis Impends"—1951. The findings of that study are similar to those of the Secretary's Commission which you just heard reported. That study concluded with the warning, the Secretary's study—with the warning that: "It is the sincere belief of the Commission that the health of this Nation will be at risk if the changes suggested in these recommendations do not occur." You can note that none of the Commission's recommendations involves recruitment of foreign nurse graduates to augment the Nation's nursing force. In fact, in its interim report to the Secretary in July it stated that it opposed this practice.

There are major concerns in terms of the recruitment of foreign nurse graduates, and an important one is the protection of the public. The examination required in every State for licensure ensures the minimal level of knowledge for safe nursing practice. Foreign nurse graduates, as a group, have in the past an extremely poor record on this exam, as you have heard earlier.

Consider the advantages costwise of using the money for recruitment that is being used for the recruitment of foreign nurse graduates as an investment in a scholarship for American students in return to post-graduation employment or the investment in American nurses and their long-term committed employment by increasing their salaries with the money used.

There are also ethical dilemmas involved in the recruitment of foreign nurse graduates. Consider those nurses recruited to work

here but unable to pass the licensing exam. What has happened, for example, to the over 1,500 foreign nurse graduates who failed the California exam in 1988 on their first writing, and what about the 6,500 others who failed that exam that same year on repeat writing? Did these nurses return home hurt and humiliated? Were they placed in positions below their professional and financial expectations? Are they still caring for patients without demonstrating safe nursing knowledge?

Another ethical concern is the drain of nurses from countries that are also facing a nursing shortage. Israel is one, as you will note.

Although it is difficult to document, anecdotal reports are convincing that utilization of foreign nurse graduates does adversely affect the income and employment conditions of American nurses. The Texas Nurses Foundation in 1988 notes that: "During the nursing shortage in the 1970's, Texas relied on foreign nurse graduates as a substitute for adopting a long-term solution. That strategy is believed to have exacerbated the severity of the current shortage."

H.R. 2111 addresses increasing the American nurse power, and I commend this. It provides for financial assistance for programs that will promote the recommendations of the Secretary's Commission on Nursing noted earlier. Nurses are a critical national resource in both civilian and military arenas in promoting health as well as caring for the ill and injured. We are keenly aware of the crisis facing our Nation because we are too few. We will change this given the support requested. We can do no less.

Mr. MORRISON. Thank you very much, to all of you.

[The prepared statement of Ms. Stewart follows:]

PREPARED STATEMENT OF RUTH F. STEWART, R.N., UNIVERSITY OF TEXAS NURSING SCHOOL

Mr. Chairman and members,

I appreciate the opportunity to meet with you today.

I am Ruth F. Stewart, RN, Associate Professor at The University of Texas Health Science Center at San Antonio School of Nursing. I am past-president of Texas Nurses Association and currently Special Advisor to its Governmental Affairs Committee. I appreciate this opportunity to comment on HR 1507, "Immigration Nursing Relief Act of 1989" and HR 2111 "Emergency Nurse Shortage Relief Act of 1989."

I am gravely concerned with the crisis resulting from inadequate numbers of nurses to meet our national health care needs. I appreciate the efforts of Congress to address the problems.

HR 1507 does provide partial and temporary help in allowing Foreign Nurse Graduates (FNGs) with H-1 visas to become "special immigrants" and to continue to contribute to nursing.

These nurses are currently licensed as registered nurses and surely have learned something about our culture and legal operations that is essential to safe, effective nursing care. The initial high cost of recruiting, relocating, and orienting them has already been invested. Allowing them to continue to practice nursing is preferable to replacing them with a new wave of FNGs.

However, as the Commissioner of Immigration and Naturalization Service, Alan Nelson, captioned a recent article (attached)... "Immigration: A short-term strategy, not a long-term cure." Development of a system to ensure meeting our national needs for nurse-power is critical. Continued reliance on FNGs is unconscionable. The provisions of Section 3 of the bill do provide controlled conditions under which institutions can recruit FNGs, which is helpful. The basic problem is more complex.

The issue of attaining and retaining nurses in the health care system is not new. A study in my state in 1951 was titled Texas nursing in review: A crisis impends. The findings of the 1951 study are similar to those of the 1980's. The most recent study was requested by Secretary of Health and Human Services Bowen, and reported to him in December 1988. The recommendations are attached. The commission, comprised of 25 nationally recognized members (nurses and non-nurses), concluded the study with the warning that "It is the sincere belief of the commission that the health of this nation will be at risk if the changes suggested in these recommendations do not occur."¹

You will note that none of the commission's recommendations involves recruitment of FNGs to augment the nation's nursing force. In fact, in its Interim Report to Secretary Bowen in July 1988, it stated:

Foreign nurses cannot be relied upon as a source for significantly increasing the overall domestic supply of RNs. Expansion of the use of foreign nurses is problematic because of a number of factors: the limited supply of qualified nurses in source countries; U.S. immigration and foreign emigration restrictions; language barriers which potentially affect perceptions of service quality; and state licensure requirements. Beyond these factors, the propriety of drawing nurses from countries which may themselves have serious health care needs is of concern, as is the desirability of relying on foreign sources to solve domestic shortages.²

Fortunately, recruitment of FNGs is limited to about 10% of all hospitals³. However, even this proportion involves grave concerns.

Protection of the public

The examination required in every state for licensure as a registered nurse (RN) ensures the minimal level of knowledge for safe nursing practice. FNG's, as a group, have an extremely poor record on this exam. In the years 1969-1978 about 82,000 FNGs were admitted to this country, but only about 15% passed the exam. Many of those passing had written the exams two or three times before finally passing. The state-board pass rate for FNGs has improved since 1978 because of a screening examination that must be passed before an H-1 visa is granted to unlicensed FNGs. This exam, developed and administered by the Commission on Graduates of Foreign Nursing Schools (COGFNS), is offered at 50 sites in 35 countries outside the US. It tests for English proficiency as well as nursing knowledge. Success in this COGFNS exam does not guarantee passing a state board exam, but the probability is high with about 90% pass rate.⁴

However, there are difficulties with the practice of licensed FNGs, greater than US graduates, because of deficiencies in cultural awareness and legal knowledge of practice. Texas has statutory requirements for reporting unsafe nursing care (since 1987) and a disproportionate number of those reported are known to be FNGs. One such nurse, recently named in a malpractice suit, had no concept of her legal responsibility to her patients and could not understand how she could be sued.

As a nurse educator, I am keenly aware of the difficulty in educating our own students in legal aspects of nursing, and can sympathize with the FNGs plight. However, the public must be protected.

Florence Nightingale once said tellingly that "the first requirement in a hospital is that it should do no harm." Safe nurses are essential to this and should be a priority consideration of every hospital - - - and their patients!

Economics of Foreign Nurse Graduates Recruitment

The costs of recruiting FNG's leaves one wondering why any employer would choose this temporary method of filling positions! Recruitment costs for any nurse average \$7000, according to the American Hospital Association. This includes the cost of low productivity during orientation.⁵ The FNG necessarily requires an even longer period of adjustment and more intensive assistance and supervision than a graduate of US schools. This cost, along with transportation (airfare Manila to New York is over \$2,000) and other relocation costs make foreign recruitment an expensive source of nursing personnel.

Compare this to an alternate investment in a scholarship for an American student in return for post-graduation employment. Although national figures on the current costs of nursing education are not available, a 1972-73 Institute of Medicine study indicated per student costs of \$3,330 for two years community college and \$10,000 for four years baccalaureate preparation.⁶

Or compare the costs of FNGs to investing in American nurses and their long-term, committed employment, by increasing their salaries with the money used for recruitment.

Ethical Dilemmas of Foreign Nurse Graduates

Many FNGs, licensed as RNs, are participating effectively and happily within the American health care system. However, consider those nurses recruited to work here, but unable to pass the licensing exam. What has happened, for example, to the 1503 FNGs who failed the California exam in 1988 on the first writing? And what about the 6,451 others who failed that exam during the same year on repeat writing?⁷ Did these nurses return home hurt and humiliated? Were they placed in positions below their professional and financial expectations? Are they still caring for patients without demonstrating safe knowledge level?

Another ethical concern is the drain of nurses from countries that are also facing a nursing shortage. Israel is one of these, and the February 4, 1989 edition of the Jerusalem Post International Edition describes the problem.

THE JERUSALEM POST INTERNATIONAL EDITION

'500 nurses plan to emigrate to U.S.'

By JUDY SIEGEL
Post Science and Health Reporter
The Nurses' Union claims that 500 nurses are planning to emigrate to the U.S. in response to advertisements by a foreign company looking for candidates to fill jobs in American hospitals.

Ilana Cohen, head of the union's hospital division, sent a telegram last week to Health Minister Ya'a-

cov Tsur, warning of the danger of emigration among nurses.

"We nurses belong here, even though our wages and conditions are not appropriate to the education, experience and effort our work requires," she said. She urged the minister to take action to reduce competition from America, which has a shortage of nurses as severe as Israel's.

Foreign Nurse Graduate Impact on American Nurses

Although it is difficult to document, anecdotal reports are convincing that utilization of FNGs adversely affects the income and employment conditions of American workers.

The Texas Nurses' Foundation (1988) notes that:

During the nursing shortage in the 1970's, Texas relied on FNGs as a substitute for adopting a long-term solution. That strategy is believed to have exacerbated the severity of the current shortage.

The report concludes that:

The viability of greater recruitment of FNGs as a solution to the shortage will depend to a large extent on what the federal government does in permitting greater immigration of FNGs. Much will also depend on whether FNGs are used to avoid making changes that would make nursing a more attractive career option.⁸

Let us work together, health care providers, public officials and concerned consumers - in making those changes that will make nursing an attractive career and protect the health of our nation.

Increasing American Nurse Power

HR 2111 provides for authorization of and financial assistance for programs that will promote the recommendations of the Secretary's Commission on Nursing noted earlier.

Nurses are a critical national resource, in both civilian and military arenas, in promoting health as well as caring for the ill and injured. We are keenly aware of the crisis facing our nation because we are too few to meet the increasing needs. We will change this, given the support requested in HR 2111 and the support of the health care systems and other providers with whom we share the responsibility. We can do no less.

References

1. USDHHS (1988, December). Secretary's Commission on Nursing, pp. vi-ix.
2. USDHHS (1988, July). Secretary's Commission on Nursing, Interim Report, Executive Summary, p.8.
3. American Hospital Association data, presented by Connie Currau, Ph.D., R.N. to the Secretary's Commission on Nursing, December, 1987.
4. Commission on Graduates of Foreign Nursing Schools data, presented by Ann Zimmerman, R.N., to the Secretary's Commission on Nursing, March, 1988.
5. American Hospital Association. (1987). Surviving the nursing shortage, p.47.
6. State of Texas. (1988). Report of the Special Committee on Post-Secondary Medical, Dental and Allied Health Education.
7. California Board of Registered Nurses. (1988). 1988 Licensing Examination Results.
8. Texas Nurses' Foundation. (1988). Texas nursing shortage: Strategies and solutions, p. 13.

Secretary's Commission on Nursing¹

Recommendations

Utilization of Nursing Resources

1. Health care delivery organizations should preserve the time of the nurse for the direct care of patients and families by providing adequate staffing levels for clinical and non-clinical support services.
2. Health care delivery organizations should adopt innovative nurse staffing patterns that recognize and appropriately utilize the different levels of education, competence and experience among registered nurses, as well as between registered nurses and other nursing personnel responsible to registered nurses, such as licensed practical nurses and ancillary nursing personnel.
3. The federal government should sponsor further research and encourage health care delivery organizations to develop and use automated information systems and other new labor-saving technologies as a means of better supporting nurses and other health professionals. Health care delivery organizations should work with researchers and manufacturers to ensure the applicability and cost-effectiveness of such information systems and technologies across all practice settings.
4. Health care delivery organizations, nursing associations, and government and private health insurers should collaborate to develop and implement methods for costing, budgeting, reporting and tracking nursing resource utilization, both to enhance the management of nursing services and to assess their economic contribution to their employing organization.

Nurse Compensation

5. Health care delivery organizations should increase RN compensation and improve RN long-term career orientation by providing a one-time adjustment to increase RN relative wages targeted to geographic, institutional and career differences. Additionally, they should pursue the development and implementation of innovative compensation options for nurses and expand pay ranges based on experience, performance, education and demonstrated leadership.

Health Care Financing

6. Government should reimburse at levels that are sufficient to allow efficiently-organized health care delivery organizations to recruit and retain the number and mix of nurses necessary to provide adequate patient care.

Nurse Decision Making

7. Policy-making, regulatory, and accreditation bodies that have an impact on health care at the national, state, and local levels should foster greater representation and active participation of the nursing profession in their decision-making activities.
8. Employers of nurses should ensure active nurse participation in the governance, administration, and management of their organizations.
9. Employers of nurses, as well as the medical profession, should recognize the appropriate clinical decision making authority of nurses in relationship to other health care professionals, foster communication and collaboration among the health care team, and ensure that the appropriate provider delivers the necessary care. Close cooperation and mutual respect between nursing and medicine is essential.

Development of Nursing Resources

10. Financial assistance to undergraduate and graduate nursing students must be increased. The burden of providing this assistance should be equitably shared among the federal and state governments, employers of nurses, philanthropic and voluntary organizations. The preferred method of providing this support is the use of service-payback loans as well as scholarship funding for those in financial need.
11. State governments, nursing organizations, schools of nursing and employers of nurses should work together to minimize non-financial barriers to nursing education for individuals desiring to enter the profession as well as for nurses wishing to upgrade their education.
12. Schools of nursing, state boards of nursing, and employers of nurses should work together to ensure that the curricula are relevant to contemporary and future nursing practice, prepare nurses for employment in a variety of practice settings, and provide the foundation for continued professional development.

13. The nursing profession should take primary responsibility for providing immediate and sustained attention to the promotion of positive and accurate images of the profession and the work of nurses.

Maintenance of Nursing Resources

14. The Department of Health and Human Services should create a commission having a duration of at least five years that will monitor the implementation of the recommendations in this report as well as the development and maintenance of nursing resources. This commission should be constituted as an advisory body reporting directly to the Secretary.
15. The Department of Health and Human Services, private foundations, and employers of nurses should support and carry out research and demonstrations on the effects of nurse compensation, staffing patterns, decision-making authority, and career development on nurse supply and demand as well as health care cost and quality. Research should be sponsored on the relationship of health care financing and nursing practice.
16. The federal government should develop data sources needed to assess nursing resources as they relate to health planning and manpower.

SOUNDING BOARD

Immigration: A Short-Term Strategy, Not a Long-Term Cure

by ALAN C. NELSON

WHAT CAN be done about the nursing crisis in the United States? There are two basic approaches that can offer effective solutions: efforts by the health care industry to improve wages and working conditions for nurses, and congressional action to change our immigration laws to allow foreign nurses and persons with other needed skills to immigrate to the United States when there are shortages of domestic workers.

The Immigration and Naturalization Service (INS) recently acted to relieve the short-term labor problem in health care facilities that employ nurses. INS determined that the nursing shortage constituted an extraordinary circumstance, which warrants a blanket sixth-year extension for foreign nurses in the United States on temporary H-1 visas.

This action was based on a clear commitment from employer groups to take positive steps to resolve the shortage without continued dependence on foreign nurses holding temporary visas. Future extensions are not contemplated. In acting on this issue, INS worked with many members of Congress, individual employers, hospital associations, the American Nurses' Association, committees of Congress, and the Department of Health and Human Services.

The extension granted by INS does not resolve the long-term problem, however. Congress must take action to meet the needs of American employers. In 1986, the Congress, acting in concert with the Reagan administration, passed legislation to combat illegal immigration. Now Congress must turn its attention to legal

immigration. Current law fails to meet the needs of American employers and contains only limited provisions for addressing the changing needs of the American labor market.

The Senate last year made an effort with passage of the Kennedy-Simpson legal immigration reform legislation. However, the bill died when it was not acted upon by the House. The bill, which dealt with legal immigration, included bringing persons with needed skills into the United States. Nurses could certainly be such a group.

Legal immigration reform can and should be reintroduced and passed in this Congress. The nursing crisis should be a catalyst for action. The congressional leadership must act if this needed legislation is to become law.

As for the nursing issue itself, it is abundantly clear that hospitals, nursing homes, and other health care facilities have not done enough to recruit and retain nurses or to attract people into the nursing profession. Experts on nursing have indicated that the shortage of nurses can be minimized if health care facilities will implement measures such as the following, which have proven effective in recruiting and retaining nurses:

- improve nurses' wages and working conditions;
- provide loans and scholarships for in-house personnel such as LPNs and nurse's aides who may want to become nurses;
- bolster support systems for nurses to relieve them of administrative and non-clinical duties, thus allowing them to concentrate on nursing activities; and
- offer more flexible employment in terms of hours and types of patient care desired.

The Immigration and Naturalization Service will continue to work with Congress and with health care organizations to do what it can under the statute to assist with the nursing crisis; however, health care facilities must take the initiative in resolving the nursing shortage over the long term.

ALAN NELSON, JD, is commissioner of the United States Immigration and Naturalization Service.



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Mr. MORRISON. Dr. Gibbons, one of the points that you made was that a very significant portion of the work time of nurses is spent in tasks which they are not necessarily uniquely qualified for and which would be discharged by other individuals. Why is that true? Is that a labor shortage of its own, or what kind of management practices cause those tasks not to be assigned to other personnel? And I assume that these are personnel whose training and skill level is lower rather than higher R.N.'s. Is that right?

Ms. GIBBONS. Sometimes, yes.

Since 1983, since the onset of prospective payment, there has been a decline of 125,000 nurses' aides and LPN's in the practice environments in our country. At that time, nurses started to substitute for the tasks that the licensed practical nurses and the nurses' aides were carrying out in relation to patient care.

Mr. MORRISON. When you say there was a decline, is this a decline in relative numbers or in absolute numbers?

Ms. GIBBONS. Absolute numbers. There were massive layoffs.

Mr. MORRISON. So people were laid off because when money was short those were the jobs that were eliminated.

Ms. GIBBONS. And that was at the outset of prospective payment. Before, we really talked about money being tight. It was the anticipation of cost containment because—I think you are probably very familiar with the profit margins in hospitals have just started to decline in the past year, but prior to that the first 2 years of prospective payment the hospital profit margins were relatively high. But at that time they did try to contain costs by looking at personnel costs, which account for 70 percent, on the average, of a hospital's payroll—of a hospital's budget, overall budget.

So cutting down on other types of workers, such licensed practical nurses and nurses' aides, was one of the strategies that have been employed across the country. At the same time, nurses believe that the patient acuity had been beginning to increase and felt it was more important for an all R.N. staff. So, therefore, we saw a 38,000 increase in registered nurses during this period of time, 1983 to 1988, at the same time there was a decline in other types of nursing personnel.

Mr. MORRISON. Who was it that thought that the all R.N. staff was the proper way to go.

Ms. GIBBONS. Nursing administrators in the hospital environment.

And part of that issue then was looking at the types of work that nurses were doing. We knew, too, that the other allied health professionals, such as physical therapists, respiratory therapists, are in great demand are on the decline also in the hospitals. Vacancy rates in those particular positions are increasing at a faster rate than the registered nurse positions. Registered nurses are substituting for those other professionals. They are substituting, doing some of the work that the physical therapists and respiratory therapists also would be doing.

You mentioned that this was going to, in the long term—the Bureau of Labor Statistics presented some data to us in the latter part of the Commission year and predicted that there would be 900,000 new jobs in the health care industry between now and the year 2000. That is within 11 years.

What the Commission realized after looking at what it is that nurses are doing, and looking at the studies that suggested anywhere from 30 to 60 percent of the activities that nurses are doing are activities that other types of workers could be doing, and most of them being lower levels of workers, could be assisting in certain kinds of patient care activities, environment activities, as well as technology for information. Information—automated information systems are long overdue in the hospital environment in this country.

So putting all that together and looking at how we can improve the utilization of the registered nurse, clearly, that nurse has been misutilized for a number of years, not just this shortage, it has happened in the past. This shortage, what makes it different from the rest is that there is also a concomitant decline in the enrollments in schools of nursing for all the reasons that we know—the image of nursing but also the opportunities that are available for women today to select other types of careers.

But if we look at the decline in the hospitals in this country, one might say—if we look at hospital closures, we might not have this same demand for nurses in the future. We did do an analysis on that, and we thought, the hospitals are closing, and 50 percent or more of the hospitals that are closing are the small, rural institutions.

If we look at the major urban institutions, they have a growing demand, and we talked about the situation in New York, for example, with the growth in the HIV virus and the implications that has for nursing care as well as the other types of intensive, invasive procedures that are being done today. We studied the DRG's from 1983 to 1988, looked at the top 10 DRG's in the country—very different patient populations in those two periods of time. You can clearly see the acuity level is much graver now, demanding much more nursing care at the bedside.

Mr. MORRISON. The bottom line: If there were an expansion of the other personnel as opposed to an expansion of nurses and a transfer of responsibilities, would we not be dealing with a nursing shortage at all?

Ms. GIBBONS. That is a hypothesis that needs to be tested. If one looks at—if we took 40 percent of the tasks away from nurses that could be done by other levels of workers. We would have more work for the nurses with dealing directly with patients and perhaps wouldn't have as much as a demand for registered nurses. But that means that the institution has to be willing to buy, to purchase, to hire new types of workers to come in and assist in the patient care.

Mr. MORRISON. But they have been expending very large sums of money and raising nursing salaries and in recruitment efforts and all the rest. Why do they make that choice? I mean is there something else going on here besides pure economics?

Ms. GIBBONS. Clearly, just taking the wage issue first, nurses have been significantly underpaid for the work and responsibility that we have in the profession. The wage progression for nurses over the life of the career from start to finish has been 39 percent.

Last year, because of the response on the part of the industry, or the market, to try and increase wages, we see now that the pro-

gression is now 44 percent progression from start to finish. Witness a secretary's start to finish; BLS data suggests that it is an 82-percent increase; engineers, 198-percent increase; accountants, 192-percent increase.

So we are talking about what is an average, what would be acceptable. Probably a 100-percent increase over the life of a career to make it a worthwhile effort for women and men and to draw perhaps more men into the profession who would need to have more economic incentives, and given the 24-hour coverage—evenings, nights, weekends, and holidays—that one needs to be paid higher for that type of service that is provided during those off-hours or the unacceptable as far as our society routines are concerned.

Clearly, the hospital industry has a major responsibility to restructure the health care environments to be able to more effectively and efficiently utilize the personnel that they currently have and then to hire the types of services and the personnel that they need to support patient care.

Mr. MORRISON. Why is that a purely private sector obligation? Given the regulatory environment, the cost containment concerns, it seems a little out of place to say the hospitals have to restructure. If what the hospitals did was restructure, they restructured in response to regulatory changes, and the restructuring it seems that you are finding was at least in part inappropriate and leading to a badly structured labor market where we have to keep raising the compensation of nurses to try to get them in and come work in a lousy environment without adequate support personnel.

Some would say we can never pay enough to get people to stay in that kind of a work environment. At the same time, we are going to leave it to those people who made that decision to get around to fixing it. Does that make any sense?

Ms. GIBBONS. I'm speaking for the Commission, not for the Department, and it's clear on the part of the Commissioners who produced the report that a private/public sector initiative is called for, that the Government, as well as the hospitals, as well as nursing, as well as medicine in this country come together to implement, to develop, a multilevel implementation plan.

Our strategies gave specific areas that need to be further operationalized into a plan, and that is what is called for, but, again, in a 1-year commission that is all we were able to do. But what happens now is something that is up to Congress perhaps and the Department.

Mr. MORRISON. Thank you.

Mr. Smith.

Mr. SMITH of Texas. Thank you, Mr. Chairman.

Ms. Stewart, let me say again it is nice to have a friend here from San Antonio, and so far as I can tell, you came the farthest distance to testify before us today, and that is appreciated.

Let me follow up a little bit indirectly on some of the questions that have been asked. You and I were talking briefly before the hearing convened about the fact that it seems that in some areas—in the same general area, you may have a hospital that is suffering from a shortage of nurses and you may have a hospital that is not

suffering from a shortage of nurses. What role do you think the hospitals themselves play in the nursing shortage?

Ms. STEWART. I do agree that the restructuring of the hospitals is essential to reducing reliance, or their problem with nursing shortage. The Commission's report clearly states that. There have been all kinds of reports that have demonstrated that there are hospitals in this country that have no problem with the nursing shortage, and from an anecdotal report, I was visiting last night with a young nurse friend who has previously worked in Dallas and is now in this area, and she compared working in two institutions in Dallas, one of which she got out of, which also, incidentally, had a very high rate of foreign nurse graduates in it. She went on to another institution and said it was wonderful to work there and she was so lucky, because the only reason she got on the staff there was because they had opened a new ICU. They did not have frequent vacancies. This, I think, we can find across the country.

Mr. SMITH of Texas. Do you think a good part of the nurses shortage is due to ineffectual management on the part of the hospital administrator?

Ms. STEWART. I don't know whether it is ineffectual in some areas, but it is certainly ineffective in terms of the support systems for nurses.

Mr. SMITH of Texas. Do you think we would still have a nurses shortage if all hospitals were run well? Do you think that the numbers are just not there and the crisis would be alleviated by better run hospitals, or do you think—

Ms. STEWART. I wish I had a crystal ball for that. I'd hate to really get into that. But I do feel very, very strongly that it would certainly make a big dent in it.

Mr. SMITH of Texas. A big difference. OK, I appreciate that.

You mentioned in your testimony that continued reliance on foreign nurses is unconscionable. In addition to anything else that we have talked about, what do you think we should do to attract individuals to the nursing profession here in America?

Ms. STEWART. I think that the financial help and support of the Federal Government is important. Nursing is a national resource that is very critical. I do realize that we cannot continue to rely on Government for all things, but certainly that support for—with military being also a big sector that is also facing a shortage right now.

I do think, though, that what we are doing, the recommendation of the Commission, are important. I agree with the public/private sector support system. Nursing organizations, all of our major nursing organizations, are working; they are working to improve the image of nursing, they are working to recruit, to make nursing relatively reported as the attractive, stimulating, caring profession that most of us know it as.

Mr. SMITH of Texas. OK. Thank you.

Let me ask Ms. Hatcher a question, which is that you say in your testimony, "In the absence of H-1 nurses, the prevailing wage rate would rise in the case of New York City." While I happen to agree, do you have any data to base that statement on? What is your reason for believing that the wage rate would rise?

Ms. HATCHER. No. I think, as my statement went, that we really need to look into—there's the Booz-Allen study that showed that there might—that the use of H-1 visa nurses may be impacting the decline or the inability of hospitals to raise salaries to perhaps attract nurses, and I think my statement was that we really need to get further data to find out if this is actually true or not.

Mr. SMITH of Texas. OK.

Thank you, Mr. Chairman. I don't have any other questions.

Mr. MORRISON. Mr. Schumer.

Mr. SCHUMER. Thank you, and I want to thank everyone for their testimony, which I have gone over.

My first question is for Ms. Stewart.

Everything in your testimony seems to agree with H.R. 1507, yet you haven't taken a specific position on the bill. Do you endorse the general approach?

Ms. STEWART. Yes.

Mr. SCHUMER. You do. OK. Good. I'll quit while I'm ahead there.

The next question is for Ms. Lowery.

What is your estimate as to how many of the people who come in on the H-1 visas stay in nursing? If you were in the room before—I believe you were—when we were discussing that 80 percent of American nurses, American born and trained nurses, are in nursing—of course, not all of them are in patient care nursing, but they are working as nurses—what estimate would you give for the number of people who are in nursing, who have come in on H-1 visas and are still in the profession?

Ms. LOWERY. Roughly, I would say between 95 to 100 percent—not really 100, but they have to work as nurses to maintain their H-1 status.

Mr. SCHUMER. Right, right.

Ms. LOWERY. Now, what happens after they get married or obtain their permanent visas is—we don't have data on that, but from personal experience I know that they continue to work.

Mr. SCHUMER. OK. So you would estimate that at least those who are still as H-1's, the overwhelming percentage are still in nursing. Do you have any doubts that if these people achieve permanent resident status that they will continue working in nursing, the vast, vast, vast majority?

Ms. LOWERY. I think they would continue to work in nursing.

Mr. SCHUMER. What would be your view of the administration's proposal that they should be required to stay in nursing for 2 or 3 years after they get their permanent status? It is sort of a contradiction in terms between permanent status and being required to work somewhere, but let's say we put that in, what would you think?

Ms. LOWERY. Well, I think that voluntary versus mandatory is not too palatable—I mean mandatory versus voluntary is not too palatable.

Mr. SCHUMER. I understand. OK.

Mr. SMITH of Texas. Will my colleague yield for a second?

Weren't you the author of a bill that extended the visas by 1 year last year or the year before?

Mr. SCHUMER. Yes, I was.

OK. The next question is for Ms. Hatcher.

Do you believe there are abuses in the current H-1 program with respect to foreign nurses?

Ms. HATCHER. We hear of them, yes. I do believe there are.

Mr. SCHUMER. Could you tell us a little bit? Just elaborate a bit.

Ms. HATCHER. Well, I think to some extent with some of the recruitment efforts and the stories we hear there may be abuses in certain countries and with certain kinds of agencies. So there is, I think, some exploitation of the nurses. I do not think to the extent that it may have been in the past, but there are some.

Mr. SCHUMER. What is your belief? Let's say we extended permanent resident status to H-1 nurses under the bill. Do you think there would be large defections from the nursing field among nurses?

Ms. HATCHER. No, I really don't. I think you would see the same kind of participation rate that you are getting from other nurses.

Mr. SCHUMER. OK. That's it for me. I want to thank all the witnesses.

Mr. MORRISON. Ms. Stewart, you asked some good questions that you didn't give us the answer to and we didn't ask anybody before you, so do you know the answer to your question about what happens to those who fail the exam?

Ms. STEWART. I cannot speak for California. The figures that I gave you were the 1988 report of their board exams. I do know that in Texas—I say I know; again, all this information has to be anecdotal. It's very difficult to pin down the kinds of information, again, that was asked of Ms. Hatcher, because it is controlled by forces outside of nursing. But I do know that in my State, before we started using the CGFNS exam, which was referred to, which is a screening exam now, before the H-1 visa is allowed, that we did have grave, grave problems. We did have, again, the high percentage of failures.

We do know that those nurses continued to practice in many instances in the same professional—supposedly professional category that they had when they were on a temporary licensing permit. We do know that they were called charge nurses, head nurses, supervisory nurses, they could not be called R.N.'s because they had not passed the exam, but they had not passed the exam.

If even language is the reason for that problem, the English language is what the orders are written in, what the medications are labeled in, and what the majority of the patients speak.

Mr. MORRISON. So what you are saying is that, technically speaking, those individuals who failed to get licensed were out of status as far as their right to be here.

Ms. STEWART. No, they were not at that time in Texas. That was a few years before. But I'm saying that those States that are still—I don't know what is going on in California. I know those are the figures. That is a lot of nurses that are still—are people that took the licensing exam that are some place, and I suspect they did not go home, most of them.

Mr. MORRISON. But, in theory, they should have to go home if they haven't achieved licensing. Isn't that right?

Ms. STEWART. That's right.

Mr. MORRISON. If we were to take Mr. Schumer's approach, would we be giving permanent residence to a large number of people of that sort?

Ms. STEWART. No, because his bill does refer to those that are already licensed, so that would not be the case with those, and that was the point that I made. They have been here, they have passed the licensing exam, they have worked from whatever to whatever years. I understand there have been several extensions at different times, so that those nurses would have been acculturated and, to a great extent, familiar with our legal system, which is one of the problems too. That is not handled in any of our exams, because every State has different laws.

Mr. MORRISON. OK. Thank you very much.

Mr. Smith, any further questions?

Mr. Schumer.

I want to thank you all for your testimony.

Our next panel, I would like you to come forward and remain standing to be put under oath: Arthur A. Sponseller, from the California Association of Hospitals and Health Systems; Beverly Bradshaw, Dallas-Fort Worth Hospital Council; Stephen Cooper, vice president of the Hospital Association of New York State; Ira Clark, Jackson Memorial Hospital, Miami, FL; Irene McEachen, vice president for nursing at Beth Israel Medical Center; and Ms. McEachen will be accompanied by Susan Walter, the general counsel of the Greater New York Hospital Association.

Would you raise your right hand.

[Witnesses sworn.]

Mr. MORRISON. Please be seated.

I want to thank all of you for being here today, and your written testimony will be made part of the record, and, please, we have a large panel, and I don't want to be impolite and interrupt you, but if you would please try to summarize your testimony within the 5-minute period it would help us all.

We will start with Mr. Sponseller.

STATEMENT OF ARTHUR A. SPONSELLER, CALIFORNIA ASSOCIATION OF HOSPITALS AND HEALTH SYSTEMS

Mr. SPONSELLER. Thank you.

Mr. Chairman and members of the committee, I'm Arthur Sponseller, vice president of human resources for the Hospital Council of Southern California. I'm representing the California Association of Hospitals and Health Systems. Thank you for the opportunity to appear here today.

I want to start by stating that the nursing shortage is our problem as hospitals to solve, working with nursing groups and nurses and, yes, with Government, to find solutions. We appreciate your interest in this issue. We also believe strongly that foreign nurse recruitment is not the solution to the nursing shortage, but it is necessary for the time being.

We support providing special immigrant status to R.N.'s currently on H-1 visas, but we have concerns about the mechanisms, definitions, and potential enforcement issues associated with the proposed H-4 category. We think the legislation needs to address the

imposition of the 5-year time limit by the INS on H-1 visas. We can't afford to lose nurses due to the expiration of their visas, and we must keep the doors open to qualified nurses during this period of acute shortage.

The proposed H-4 category may limit the ability of hospitals to provide patient care for Americans by restricting the entry of non-immigrant nurses and thereby making it difficult for some hospitals to maintain their staffing. The intent of the new category is to encourage employers to solve the shortage domestically, which we support, while continuing to use foreign labor. However, if misinterpreted or strictly interpreted in its current form, there may be a negative result, making the process more costly, difficult, and time consuming, the impact being to cut off a critical source of supply.

The shortage is real, as we have heard this morning, and foreign nurses are necessary at the current time. Out statewide statistics collected by the association reveal a vacancy rate in 1988 for California hospitals of 8.7 percent with a significant increase in demand in the period 1972 to 1986. The percentage of R.N.'s, of total full time equivalents during that period, increased from 20.5 percent to 25 percent. In 1988, the R.N. turnover in California was 19.2 percent.

In the spring of 1988, the association conducted a survey of members to determine the impact of expiring H-1 visas and the degree of H-1 visa utilization in member hospitals; 252 hospitals responded; 33 percent reported employing nurses on H-1 visas, and 27 indicated an intention to recruit foreign nurses in 1988. Of the nurses on H-1 visas, 18 percent would expire in each of the 3 years subsequent to the survey, 45 were from the Philippines—45 percent, and 43 percent had applied for permanent residency.

The Hospital Council of Southern California is currently doing a survey of Los Angeles County in terms of H-1 utilization in conjunction with the General Accounting Office, and when that data is available we will be happy to make it available to the committee.

In addition to these statistics, I'd like to share some of the experiences of some California hospitals. I want to preface this by saying that these hospitals are doing significant activities in the areas of recruitment and retention of domestic nurses.

The first hospital is a downtown facility employing 90 R.N.'s on H-1 visas. We estimate that 15 to 20 of those will expire in the next 12 months, and half of their H-1 visa nurses are working on critical care units. In addition, this hospital has 80 vacancies.

The second hospital is a small and financially troubled inner city facility with 100 full time nurses; 16 are on visas; of the 16, 7 are expected to expire in the next 12 months.

Another hospital, moderate sized, in the downtown area of Los Angeles employs 12 nurses on H-1 visas that will expire in the next 12 months. Of those 12 that will expire, 9 are on critical care areas.

Finally, a moderate sized suburban hospital employs 14 R.N.'s on H-1 visas, one of which will expire in the next year. This nurse works in the operating room, where there are already seven vacancies. It takes this hospital an average of 6 to 9 months to fill a vacancy.

California hospitals have taken several actions to minimize the multiple forces driving the nursing shortage, such as restructuring the work environment, addressing the issue of wage compression, boosting wages, forging coalitions with educators, and advocating public policies to promote recruitment and retention. These activities are detailed in my written testimony.

Also in my written testimony I have included our specific concerns with the proposed H-4 category as well as some suggestions for how to address the 5-year time limit.

It is important to recognize that foreign recruitment is not viewed by health care employers as a solution in itself to the shortage. It is critical that we find a method acceptable to all the parties interested in this issue that will permit all nonimmigrant R.N.'s who have demonstrated a desire to stay in this country to do so and to gain permanent residency status without restricting the future immigration of R.N.'s.

We appreciate the efforts of this committee in this regard, and we recognize the disparate interests of the parties involved. But while we are in the midst of the severe nursing shortage it doesn't make sense to jeopardize patient care because the INS feels it does not have the legislative authority to make exceptions to the 5-year time limit for H-1 visas.

R.N.'s in this country on visas are tried and true nurses. We need them to take care of patients. They are a valuable resources. We need your help. We can't afford to lose them.

Thank you.

Mr. MORRISON. Thank you very much.

[The prepared statement of Mr. Sponseller follows:]

CALIFORNIA ASSOCIATION OF HOSPITALS AND HEALTH SYSTEMS



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Testimony Before The
SUBCOMMITTEE ON IMMIGRATION, REFUGEES, AND INTERNATIONAL LAW
OF THE COMMITTEE ON THE JUDICIARY
OF THE
UNITED STATES HOUSE REPRESENTATIVES

May 31, 1989

Regarding
H.R. 1507
IMMIGRATION NURSING RELIEF ACT OF 1989

Presented By:

Arthur A. Sponseller
Testifying For The
California Association of Hospitals and Health Systems

Representing California Hospitals and their Health Systems



Mr. Chairman, members of the Committee, my name is Arthur Sponseller, I am Vice President of Human Resources for the Hospital Council of Southern California. Today, I am representing the California Association of Hospitals and Health Systems.

POSITION: THIS BILL IS AN IMPORTANT STARTING POINT BUT WE HAVE CONCERNS REGARDING THE PROPOSED H-4 CATEGORY

California hospitals support providing special immigrant status to R.N.s currently on H-1 visas but we have concerns regarding the mechanisms, definitions and potential enforcement issues associated with the new H-4 category. This legislation must address the imposition by the Immigration and Naturalization Service of the 5 year time limit for H-1 visas. Hospitals cannot afford to lose qualified nurses due to the expiration of their H-1 visas. We must keep the doors open to qualified nurses during this period of acute labor shortage.

The proposed H-4 category may limit the ability of hospitals to provide quality patient care for Americans by restricting the entry of non-immigrant nurses and thereby making it difficult for some hospitals to maintain required staffing ratios.

The intent of the new H-4 category is to encourage employers to solve the nursing shortage domestically while continuing to use

foreign labor. However, if misinterpreted or strictly interpreted in its current form the H-4 may have a negative result by making the process more costly, difficult and time consuming. The impact may be a cutting off of this critical source of supply as employers are unable to devote the time and dollars to process applications for the new category. If this were to occur, the resulting financial hardship caused by the increased vacant positions would reduce the resources otherwise available to solve the nursing shortage. If hospitals have to close units or curtail services because foreign nurses are no longer available, they will not have the resources to continue making long term changes necessary to solve the shortage.

FOREIGN RECRUITMENT IS A NOT A PANACEA FOR THE SHORTAGE

Foreign nurse recruitment is not the answer to the nursing shortage and California hospitals do not see it as the way to solve the nursing shortage. Because the shortage is driven by significant demographic and societal changes, no single activity (in this case foreign nurse recruitment) can be relied on to solve it. The time and cost of foreign recruitment, the higher than average state board failure rate of foreign nurses, and the high rate at which nurses voluntarily return to their home countries combine to make foreign recruitment a "last resort" activity. Hospitals would

prefer to recruit staff domestically. Even if all shortage solutions were universally implemented today, there are not enough nurses available in the domestic market who could take the place of foreign nurses. Recent studies indicate the growing demand for nurses is greater than ever before. Over 80% of all nurses actively work in nursing. Shortage solutions currently underway will take many years to reverse the demographic trends we are facing. In the meantime, for some hospitals foreign recruitment is a necessity. Our studies indicate that less than 30% of hospitals in California intend to recruit or hire employees on H-1 visas, whether recruited domestically or offshore. For those hospitals, however, non-immigrant nurses are a critical resource. Despite the current administrative and financial costs it may be the only way some facilities can fill the gap between nurses they can recruit locally and their staffing demands. More importantly, for many hospitals the non-immigrant R.N.s already in this country are the difference between caring for patients and closing units. Moreover, this resource pool has a demonstrated track record of competence. We cannot afford to exacerbate the current shortage by losing nurses in the U.S. on H-1 visas, a threat because of The Immigration and Naturalization Service regulations that created the 5 year time limit. It is this issue that California hospitals believe needs to be addressed by this legislation and which will have a serious impact on patient care if not corrected. It is not

the fault of the nurses or hospitals that nurses who have applied for permanent residency and been approved must wait longer than their visas will permit. Nor is it the fault of nurses who have been unable to apply for permanent residency that they now may not have sufficient time to get their "green card" before their visas expire. This problem will worsen in the future because of the impact of the Immigration Reform and Control Act of 1986. In 1991, H-1 visas will expire for nurses who were hired after the effective date of the Act and who have been unable to establish permanent residency. Employers will not risk sanctions and will therefore be forced to terminate qualified nurses as their visas expire. We must find a way for nurses who have applied for permanent residency to remain in the United States until they have obtained their "green card." Also, to be fair, we must give all nurses here on H-1 visas the opportunity to apply for and gain approval for permanent residency.

THE SHORTAGE IS REAL

As reported by the Secretary's Commission on Nursing,

"The reported shortage of R.N.s is real, widespread, and of significant magnitude. There is evidence to support the conclusion that the current shortage cuts

across all health care delivery settings and all nursing practice areas. R.N. national vacancy rates have more than doubled between 1983 and 1987 from 4.4% to 11.3%."

In California, statewide statistics collected by California Association of Hospitals and Health Systems reveal that in 1988 the vacancy rate for R.N.s was 8.7%. Meanwhile, the demand for nurses is increasing. Between 1972 and 1986, California hospitals increased the R.N. percentage of total Full Time Equivalent (FTE) positions from 20.5% to 25%. In 1988, R.N. turnover in California hospitals was 19.2%.

USE OF FOREIGN NURSES IS NECESSARY

In the spring of 1988, California Association of Hospitals and Health Systems conducted a survey of member hospitals to assess the degree of foreign nurse utilization and the impact of H-1 visa expiration upon hospitals: 252 hospitals responded to the survey; 83 hospitals (33%) reported employing R.N.s on H-1 visas; 68 of the 252 (27%) indicated their intention to recruit foreign nurses in 1988. The numbers that follow understate the actual numbers of R.N.s on H-1 visas in California. However, the percentages are representative of the actual group. The survey results indicated

that 487 R.N.s in California hold H-1 visas: 302 (62%) work in Southern California; approximately 90 (18%) H-1 visas will expire in each of the three years subsequent to the survey, 1989, 1990 and 1991; 215 (45%) are from the Philippines; and 209 (43%) have applied for permanent residency.

Currently, the Hospital Council of Southern California is conducting a survey of its members in the Los Angeles County area of H-1 visa nurse employment in response to a request from the General Accounting Office (Exhibit 1). Final results will be available in June and the Hospital Council of Southern California will be happy to share the results with the Committee. I would like to share with you the experiences of some California hospitals:

Hospital A: This downtown facility employs 90 R.N.s on H-1 visas and they estimate 15 to 20 (16% to 22%) will expire in the next twelve months. Half of all their H-1 visa nurses are working on critical care units. They have 80 open positions.

Hospital B: This hospital is a small, financially troubled inner-city facility with 100 full-time nurses, 16 (16%) of which are on H-1 visas and 7 of the 16 are scheduled to expire in the next twelve months. Most of the nurses on H-1 visas work in

Page: /

medical-surgical areas. It takes this hospital an average of six months to fill one vacancy with an estimated cost of recruitment to hire one nurse at \$10,000.

Hospital C: This moderate sized downtown Los Angeles facility employs 12 R.N.s on H-1 visas that will expire in the next twelve months. Of the 12, 9 will work in critical care areas.

Hospital D: This moderate sized suburban hospital employs 14 R.N.s on H-1 visas, 1 of the 14 will expire by the end of the year. This nurse works in the operating room where there are already 7 openings for R.N.s. It takes this hospital an average of six to nine months to fill vacancies with an estimated cost of recruitment or hire at an average of \$15,000-20,000.

SPECIFIC CONCERNS WITH THE PROPOSED H-4 CATEGORY

Our specific concerns with H.R. 1507 are with the mechanics, definitions and implementation of the new H-4 category. As currently described in the bill this new category will require significant time and financial resources for employees, employers and several departments of the federal government. We estimate that any hospital attempting to use the proposed H-4 category will spend thousands of dollars in administrative time and legal fees

which they do not spend using the H-1. In fact, many hospitals file H-1 visa applications in-house without the aid of an attorney. The proposed Department of Labor certification under the H-4 will almost certainly require the assistance of an attorney.

LABOR SHORTAGE CERTIFICATION SHOULD NOT BE REQUIRED

(Page 5 lines 1-4; Page 5 lines 9-13)

The proposed certification by individual employer or by geographic area should not be required. The current Department of Labor certification that employment of a foreign nurse will not cause the loss of jobs for Americans should be sufficient. The reason for this is administrative economy -- when it is likely, as is the present case, that all requests for certification are going to be approved, the agency creates a blanket certification.

If these sections requiring certification are retained, then rural hospitals need to be included. Rural hospitals frequently have more severe recruitment problems than do large metropolitan areas. Rural hospitals have fewer resources to use for recruitment and retention activities. Blanket certification should be available for rural areas as well.

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SUPPORT PAYING PREVAILING WAGE RATES

(Page 5 line 6-9)

Non-immigrants should be paid at the prevailing rate for otherwise similarly situated R.N.s in a given facility. The additional requirement that employment of a non-immigrant R.N. will not adversely affect the wages or working conditions of registered nurses similarly employed is problematic. It may be difficult to draft administrative standards that would provide clear guidance on this issue. In most cases foreign nurses represent additional staff that will help to ease difficult situations caused by vacant positions. Every new employee requires some assistance from existing employees to make the transition to the work unit.

ELIMINATION OF DEPENDENCE ON FOREIGN NURSES IS NOT POSSIBLE

(Page 5 lines 10-16)

Due to the long term nature of solving the nursing shortage dependence on foreign recruitment cannot be eliminated. Continued foreign recruitment will not be used by hospitals and others to evade their responsibility to implement long-term solutions to address the shortage. This is especially true for rural and inner-city areas where the gap between demand and supply is most acute. Rural hospitals have fewer resources to use for recruitment and

retention activities. Small and large inner-city hospitals with high rates of unsponsored patients and charity care also have limited resources as do non-acute employers such as skilled nursing facilities. The term "dependence of the facility" as used in this section will be, in practicality, hard to define: what number of non-immigrant R.N.s creates dependence? Again, administrative disputes over this issue are likely.

If such a requirement is included, we believe it would work better if addressed solely on a facility specific basis by the Immigration and Naturalization Service and not the Department of Labor. The Immigration and Naturalization Service should take into account the size, location and financial condition of the facility and the significant steps listed should not be required (page 6, lines 23-25 and page 7, lines 1-14). In addition, continued employment of non-immigrant R.N.s would not be a bar to certification.

LAY-OFFS SHOULD NOT BE A BAR TO FOREIGN RECRUITMENT

(Page 6 lines 14-18)

The prohibition against foreign recruitment in the twelve months following a lay-off was apparently included to prevent potential abuse of using non-immigrant nurses to displace American workers. It is unlikely that any employer would go through the trouble of

Page: 11

foreign recruitment in order to displace existing workers--the costs would far outweigh any benefits. However, legitimate layoffs do occur and should not be a bar to hiring non-immigrant R.N.s at a future date.

California has adopted a competitive model of cost control which subjects healthcare employers to the fluctuations of the market place. A great deal of business related change can occur within a twelve month period that may require lay-offs followed by hiring at a later date. For example, a hospital could lose a third-party-payor contract in January necessitating down-sizing to adjust to a permanently lowered census in a specialty unit. Later in the year, the same hospital could acquire a different contract for a different specialty area for which it must increase staff.

If this section is retained, lay-off should be defined as permanent, excluding temporary call-offs or reduction in hours due to census fluctuations or non-use of casual, on-call, or per diem personnel.

DEFINITION OF SIGNIFICANT STEPS PROBLEMATIC

(Page 6 lines 23-25 and Page 7 lines 1-11)

This list of activities is representative of the types of activities hospitals are doing to solve the nursing shortage and all of them are occurring in California. In addition to these activities, hospitals still need to hire non-immigrant labor.

This proposed certification process will require significant financial and administrative resources by employers and government agencies. The definition of "significant steps" will be difficult to interpret causing disputes over administrative decisions. The fact that these particular items are listed may give them greater significance in the minds of the administrators who will develop and implement regulations. Many hospitals are financially unable to pay wages at a rate above market. Definitions may be a problem, e.g. what is "adequate support services," and "reasonable opportunities for salary advancement?" The answer will vary considerably from hospital to hospital depending on their size, location and financial condition. This drain on public and private resources does not make sense when we already know shortage solutions are being implemented and when we know foreign nurses do not displace American nurses.

NURSES MUST BE PROTECTED IF CERTIFICATION IS REVOKED

(Page 7 lines 22-24 and Page 8 lines 1-2)

If certification is required and revocation a possibility, it is critical that this legislation address the issue of the status of nurses working in the U.S. under an H-4 if the employer's certification is revoked. These employees need to have their work authorization protected.

CALIFORNIA HOSPITALS ARE WORKING HARD TO SOLVE THE NURSING SHORTAGE

In California we are working hard to solve the nursing shortage and these efforts will not be diminished by any foreign nurse recruitment efforts conducted by individual hospitals. Foreign nurse recruitment cannot be relied on to solve the shortage. California hospitals have taken several actions to minimize the multiple forces driving the nursing shortage, such as restructuring the work environment, correcting wage compression and boosting wages, forging coalitions with educators, and advocating public policies to promote recruitment and retention.

In 1988, California Association of Hospitals and Health Systems formed a Nursing Shortage Task Force to study the shortage issue in California and make recommendations. The resulting action plan included recommendations for action by government, California

--3-- 47

Association of Hospitals and Health Systems, the Hospital Councils and individual hospitals in the following areas: service, education, recruitment and image. A summary of the recommendations is attached (Exhibit 2).

The Hospital Council of Southern California Board of Directors issued a policy statement on long term recruitment efforts which is attached (Exhibit 3).

In 1988, member hospitals of the Hospital Council of Southern California voluntarily donated over \$350,000 to fund the first year of a health careers recruitment project. Currently those hospitals are funding a second year of operation. The Health Careers Information Center is a comprehensive health careers resource center and clearinghouse serving six counties in the Southern California region. The mission of the center is to encourage and assist young people and adults to enter a career in nursing or other health career fields. Individuals registered with the Health Careers Information Center receive educational counseling on placement into educational programs as well as career assistance for new graduates into health care facilities (Exhibit 4).

ALTERNATIVES

The need to maintain our nursing labor pool, including non-immigrants, is critical to hospitals' ability to continue to provide quality nursing care. The H-1 visa category and regulations could be maintained as they currently exist. A new "pre-immigrant" category could be created for nurses who require extensions of status beyond their 5th year in the United States. Any nurse who was the beneficiary of an approved Schedule A visa petition would be able to receive automatic extensions of stay past her/his fifth year as an H-1 because the possession of an approved petition would be conclusive evidence that the nurse was not displacing a U.S. worker. In addition, legislation creating this new category could have a built-in time extension, say of one year, for those nurses currently on H-1 visas who have not applied for permanent residency but who wish to do so. We must give the 60% of foreign nurses in California who have not applied for permanent residency the opportunity to do so. This approach has several advantages. It utilizes the existing Immigration and Naturalization Service and Department of Labor procedures and would not require significant new administrative resources. The granting of immigrant status covers only those who apply and who qualify. The H-1 visa 5 year time limit would no longer be a barrier for nurses who have decided to stay in the country and face significant

waiting periods under the quotas established for their countries of origin. It would give hospitals a greater incentive to assist their nurses to gain permanent residency status. Finally, it would keep the critical supply of foreign qualified nurses flowing.

CONCLUSION

It is important to recognize that foreign recruitment is not viewed by healthcare employers as a solution in itself to the nursing shortage. It is critical that we find a method acceptable to all parties interested in this issue that will permit all non-immigrant R.N.s who have demonstrated a desire to stay in this country to do so and to gain permanent residency status without restricting future immigration of R.N.s. We appreciate the efforts of the Committee in this regard and recognize the disparate interests of the parties involved. While we are in the midst of a severe nursing shortage it does not make sense to jeopardize patient care because the Immigration and Naturalization Service feels it does not have the legislative authority to make exceptions to the five year time limit for H-1 visas. R.N.s in this country on H-1 visas are tried and true nurses. Hospitals need them to take care of patients. These R.N.s are a valuable resource, please help us -- we can't afford to lose them. Thank you.

H-1 VISA NURSES
a survey sponsored by
Hospital Council of Southern California

NAME OF HOSPITAL: _____

NAME OF PERSON COMPLETING THIS SURVEY: _____

TELEPHONE NUMBER: _____

I. General Information

- A. Total salaried FTE RNs working in your institution as of March 31, 1989 (count all RNs involved in direct patient care): _____
- B. Total FTE RN budgeted vacant positions (count all vacant positions budgeted for RNs who provide direct patient care): _____
- C. Please estimate the total number of FTE positions filled by agency and per diem RNs on a typical day in your facility: _____
- D. Total facility average daily census for the week of April 2, 1989: _____

II. H-1 Visa Nurses: Current Staffing Levels

- A. In column A, please enter the total number of H-1 visa nurses currently working in your institution who entered the U.S. according to the dates indicated below. In column B, please enter the number of all H-1 visa nurses who, as of March 31, 1989, obtained permanent immigration status.

	<u>COLUMN A</u>	<u>COLUMN B</u>
	Number of H-1	Number of H-1 Visa
<u>Date Entered the U.S.</u>	<u>Visa Nurses</u>	<u>Nurses Who Obtained</u>
		<u>Permanent Status</u>
		<u>As of 3/31/89</u>
1. before January 1, 1985	_____	_____
2. between January 1 and December 31, 1985	_____	_____
3. between January 1 and December 31, 1986	_____	_____
4. between January 1 and December 31, 1987	_____	_____
5. between January 1 and December 31, 1988	_____	_____
6. since January 1, 1989	_____	_____

B. Please indicate the number of H-1 visa nurses and all nurses who, on a typical day, work in the following units by shift. 1, 2

Unit	Number of H-1 Visa Nurses Who Entered the U.S.						Total Number of Nurses Assigned to Unit 3, 4	
	Before 1/1/85			After 1/1/85				
	Day	Evening	Night	Day	Evening	Night	Day	Night
Medicine								
Surgery								
Operating Room								
Recovery Room								
Intensive Care Unit (include all specialty units)								
Coronary Care Unit (include progressive and step-down units)								
Labor and Delivery								
Postpartum								
Pediatrics								
Routine Nursery								
Neonatal ICU								
Psychiatry								
Rehabilitation								
Dialysis Unit								
Drug/Alcohol Detox								
Other Inpatient Unit								
Emergency Room								
Other Outpatient Unit								

Notes

- Count the actual number of nurses, not FTEs.
- If a nurse regularly works according to flexible schedule (e.g. 12 hours), count him/her in the beginning shift.
- Exclude vacant budgeted positions and all agency/per diem nurses.
- Count all U.S. and foreign trained RNs who deliver direct patient care.

III. Loss of H-1 Visa Nurses: Potential Impact

- A. In your view, if all H-1 visa nurses working in your facility who entered the U.S. before January 1, 1985 [see II(a)(1) above] were required to leave the U.S. at the end of 1989, please indicate how much hardship this would pose for your facility (check one):

- | | |
|--------------------------|-----|
| 1. Extreme hardship | [] |
| 2. Some hardship | [] |
| 3. Little or no hardship | [] |

- B. If you checked "extreme hardship" or "some hardship" above, would this hardship affect the total institution, selected units, or both (check one)?

- | | |
|---|-----|
| 1. Hardship would affect the total institution. | [] |
| 2. Hardship would affect selected units. | [] |
| 3. Hardship would affect both the total institution and selected units. | [] |

- C. If you checked either III (B)(2) or III(B)(3) above, please indicate which units would be most negatively affected if all H-1 visa nurses who entered the country before January 1, 1985 were required to leave the U.S. at the end of this year (check all that apply):

- | | |
|---------------------|-----|
| Medicine | [] |
| Surgery | [] |
| Operating Room | [] |
| Recovery Room | [] |
| Intensive Care Unit | [] |
| Coronary Care Unit | [] |
| Labor and Delivery | [] |
| Postpartum | [] |
| Pediatrics | [] |
| Routine Nursery | [] |
| Neonatal ICU | [] |
| Psychiatry | [] |
| Rehabilitation | [] |
| Dialysis Unit | [] |
| Drug/Alcohol Detox | [] |
| Other Inpatient | [] |
| Emergency Room | [] |
| Other Outpatient | [] |

IV. Loss of H-1 Visa Nurses: Potential Strategies

A. Short Term Strategies

If you checked "extreme hardship" or "some hardship" in Question III(A), please indicate which, if any, of the following strategies you would employ immediately to address this problem (check all that apply):

Strategy

- | | |
|-------------------------------------|-------|
| Close beds | _____ |
| Curtail admissions | _____ |
| Curtail elective surgery | _____ |
| Increase foreign recruitment | _____ |
| Increase incentives for RN overtime | _____ |
| Institute/expand flexible work | _____ |
| schedules for RNs | _____ |
| Seek ambulance diversion | _____ |
| Increase recruitment of American- | _____ |
| trained nurses | _____ |
| Increase nurse salaries | _____ |
| Increase the use of agency/per diem | _____ |
| nurses | _____ |
| Other (please specify): | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

B. Long Term Strategies

If you checked "extreme hardship" or "some hardship" in Question III(A), please indicate which, if any, of the following strategies you would employ in the long term to address this problem (check all that apply):

Strategy

- | | |
|-------------------------------------|-------|
| Close beds | _____ |
| Curtail admissions | _____ |
| Curtail elective surgery | _____ |
| Increase foreign recruitment | _____ |
| Increase incentives for RN overtime | _____ |
| Institute/expand flexible work | _____ |
| schedules for RNs | _____ |
| Seek ambulance diversion | _____ |
| Increase recruitment of American- | _____ |
| trained nurses | _____ |
| Increase nurse salaries | _____ |
| Increase the use of agency/per diem | _____ |
| nurses | _____ |
| Other (please specify): | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Thank you for completing this survey. Please return it no later than Wednesday, May 31, 1989 to:

Hospital Council Of Southern California
201 N. Figueroa Street, 4th Floor
Los Angeles, CA. 90012
Attention: Kathy Barry

If you have any questions, please call Kathy Barry, at (213) 250-5600 extension 709.

California Association of Hospitals and Health Systems

A Report on the Registered Nurse Shortage

Executive Summary

Registered Nurses (RNs) are essential to both quality patient care and to the hospitals that employ them. California hospitals are concerned about the current shortage of nurses and the underlying causes of this shortage.

Multiple forces have influenced the current shortage, including work environment, wage compression, inter-professional issues, and the nurse's lack of autonomy and control over her work environment. More recently, alternative career choices and opportunities for women have compounded the shortage. The current and long standing debate concerning the preparation, education and training of nurses further complicates the situation.

In response to these issues, the California Association of Hospitals and Health Systems (CAHHS) formed a multidisciplinary task force (Appendix A) of administrators, physicians, nurses, and human resource specialists to analyze the shortage and identify recommendations which will assist hospitals in retaining and recruiting nurses. Over 40 different issues relating to the nursing shortage were enumerated by the task force. The issues were categorized for analysis into three major groups: nursing education/practice, hospital environment/retention, and nursing image/recruitment. This report discusses the critical forces driving the nursing shortage and recommends short and long term solutions for California hospitals. Implementation of these recommendations will help to eliminate the cyclical nature of nursing shortages.

Recommendations

1. CAHHS should continue to support LVN, ADN, Diploma, and BSN preparation. Nursing and other health care leaders should move immediately to identify the entry level to licensed nursing. The nursing profession and employers of nurses should design the infrastructure necessary to implement any new educational models by 2000.

2. CAHHS should encourage and assist its members to conduct research of patient care delivery systems which are patient-centered and customer-oriented. Such models should promote collaborative practice, empowerment of the RN, and cost effective delivery systems. The models should utilize various levels of caregivers.

3. CAHHS should request the state and private university and college systems to identify a master plan for nursing education which provides for upward movement between all levels of programs and integrates nursing education and practice more effectively.

4. CAHHS, in cooperation with California Society for Nursing Service Administrators (CSNSA), Healthcare Human Resource Management Association of California (HHRMAC), and the Hospital Councils, should initiate a statewide professional image career recruitment campaign.

5. CAHHS should work closely with external groups, e.g., Office of Statewide Health Planning and Development (OSHDPD) and licensing boards, and other interested organizations to remove barriers and improve the climate for nurses to practice.

6. CAHHS should solicit the support and participation of the California Medical Association (CMA) to implement these recommendations.

7. Hospitals should develop formal retention and recruitment policies.

8. Hospitals should develop formal programs designed to improve physician/nurse relationships.

9. Hospitals, in cooperation with the Hospital Councils, should promote communication and support of nursing by seeking opportunities to provide scholarships and financial assistance for nursing students and by establishing strong relationships with local nursing schools.

10. Hospitals should evaluate RN salary and compensation programs in light of the current salary compression and new practice models.

A REPORT ON THE REGISTERED NURSE SHORTAGE

Problem

California hospitals reported an increase in the RN vacancy rate from 8.9 percent in 1986 to 9.7 percent in 1987. Nationally, the vacancy rate is reported to be 11.3 percent. There is also a continuing decline in the interest of nursing as a career. Since 1982, enrollment in nursing schools has decreased 14 percent. Total graduates of California nursing schools decreased 9 percent between 1986 and 1987.

There is an increase in the demand for nurses. Between 1972 and 1986, California hospitals increased the RN percentage of total FTEs from 20.5 percent to 25.9 percent. The American Hospital Association (AHA) reports that hospitals employed 50 nurses/100 patients in 1972, and, in 1986, increased to 91 nurses/100 patients. Intensity factors, an aging society, AIDS, and increasing technology will continue to keep the demand for nurses high. The supply of nurses is decreasing and the demand for nurses is increasing.

Data Collection

The task force reviewed existing literature, studies, and policy documents. Nursing educators representing vocational, associate, and baccalaureate education all made presentations to the task force. In addition, the task force heard a presentation from a representative of secondary education and from an educator involved in a national study of college freshman.

Findings

The recommendations identify an active and facilitative role for CAHHS, and support the efforts of nursing leaders as they move toward resolution of their education and practice issues. They also provide an expectation and statement of urgency for nursing service and education. Hospitals must assure that there are adequate numbers of nurses and other personnel available to care for sick people. The best way to accomplish this is in cooperation with nurses, physicians and other stakeholders. The future is now.



Hospital Council of Southern California
 CENTER OF HEALTH RESOURCES
 201 North Figueroa Street
 Los Angeles, CA 90012
 (213) 250-5600

March 24, 1987

Nursing Recruitment Crisis Program Plan

POLICY STATEMENT:

Members are encouraged to include and maintain over time as part of their recruitment programs activities that will, in the long term, increase the overall supply of trained and qualified LVNs and RNs in the Southern California labor pool. Specifically, members should consider:

1. Development of effective retention programs
2. Development of programs to improve the quality of work life for nursing employees, especially with regard to nursing practice and physician - nurse relations.
3. Development of training programs to 'grow their own' nurses such as; new grad orientation, speciality area training, and refresher training.
4. Development of career planning programs to facilitate the movement of nurses through a progression of career opportunities within each member hospital or system consistent with the services on the continuum of care offered by that member. e.g. new grad to med-surg to speciality.
5. Development of relationships with other hospitals to share the cost of training programs listed in #3 above.
6. Development of relationships with community groups and local schools of nursing to: promote health careers to young people, promote continued funding of all levels of nursing education, and assist new grad nurses with job placement.
7. Development of programs to support or adopt local grade, junior and senior high schools, Parent Teacher Associations and community service organizations (e.g. the Boy Scouts) to "plant seeds" of interest in health careers with young people and to create a positive image of healthcare.
8. Development of local job opening and applicant referral networks to help match available candidates with available openings.
9. Development of programs to share the cost of recruiting activities that can benefit all members by increasing the local supply.



A Brief History of the Health Careers Information Center

Planning for the project began in 1987, and approval to proceed, based on the HCSC Personnel Resources Committee's recommendation, was granted by the Board of Directors immediately.

Since then, intensive research and development have resulted in a final proposal which was implemented in January, 1988.

The overall goal of the Health Careers Information Center is to increase the size of the health care labor pool by:

1. The broadest possible dissemination of information on health careers.
2. The direct recruiting of young people and adults into health career choices.
3. Educational counseling and placement assistance of individuals into educational programs.
4. Career assistance services for new graduates registered with the Center.

\$376,400 was raised from 108 members to fund operations in Year 1. In November, 1988, we held a press conference to announce the Center's services to the community and the launch of a multimedia advertising campaign.

You will find an update of the responses to date, and an analysis of the inquiries received, on the back of this brochure.

As an industry, we must continue to get the word out about the need for more registered nurses and other health care personnel. The Health Careers Information Center represents one of the most comprehensive methods for recruiting health career personnel through education and community outreach. Our goal is that the health care industry will benefit from our efforts in both the long and short term.

In collaboration with Southern California's health care community, the Health Careers Information Center will strengthen our centralized capability to attract people into health careers, and track all potential candidates up to their final career selection.

Nurses

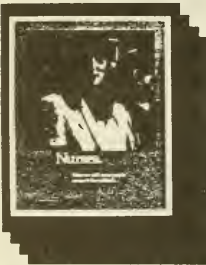
*There are still some people
we can't live without.*

Advertising & Promotional Materials



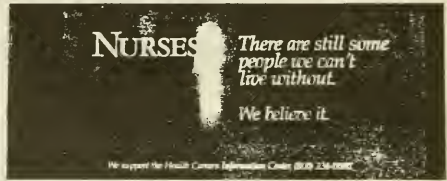
MULTI-MEDIA ADVERTISING

To reach the broadest possible audience, the HCSC media campaign includes coupon magazine advertisements in 2-color and 4-color versions. Professionally-produced television and radio commercials are available for Public Service Announcements (PSAs) and have been distributed to the major Southern California media. Newspaper advertisements are part of the plan, utilizing dominant sizes in the Sports or Women's section of the Los Angeles Times.



HIGH-QUALITY POSTERS

Five different versions of this poster (16" x 20"), printed in two colors and varnished, depict a cross-section of our target audience. They are suitable for recruiting events and posting where potential candidates can see them.



BANNERS High-quality banners silk-screened in two colors provide in-house and community recognition of your participation in the Health Careers Information Center.



PLAQUES

Participating hospitals are invited to submit a color photograph of the nurse of their choice for inclusion in a colorful, laminated plaque suitable for display in lobby or reception areas for in-house and community recognition.



LITERATURE DISPENSER AND BROCHURES

This eye-catching literature dispenser with brochures is suitable for display in high traffic areas, and usage at recruitment events.

PUBLIC RELATIONS

The Health Careers Information Center is involved in an ongoing public relations program, the results of which will be circulated to all participating hospitals via the HCSC weekly newsletter.

Mr. MORRISON. Ms. Bradshaw.

**STATEMENT OF BEVERLY BRADSHAW, DALLAS-FORT WORTH
HOSPITAL COUNCIL**

Ms. BRADSHAW. Thank you.

I'm Beverly Bradshaw, assistant director of personnel for Baylor University Medical Center in Dallas, TX, and I'm here as a representative of the Dallas-Fort Worth Hospital Council. It has 80 institutional members, and we very much appreciate the opportunity to present this testimony before the subcommittee.

The Dallas-Fort Worth Hospital Council discovered the beginning of the current nursing shortage in November 1986. Shortly thereafter, a demand survey confirmed that as of December 31, 1986, we had 1,250 registered nurse positions available. That equates to 13 percent of the total positions available. In addition, a separate supply survey showed only 700 registered nurses would graduate from area schools.

In January 1987, a very active task force of human resource experts from our hospitals put into operation a 12-point program to recruit nursing students and address the crisis for the long term. The Health Care Manpower Progress Summary Report of 1988 is included as an addendum to this testimony. It documents our successes for the past 2 years.

In the midst of our many activities, we learned that 70 nurses in the Dallas-Fort Worth metroplex had H-1 visas due to expire within a 2-year period of time. At the same time, we learned the INS proposed to cap H-1 continuous stays at 5 years. This proposed action would instantaneously add another 6 percent to our vacancy rate.

We appreciated the INS's response in June 1988 granting a 6th year extension. The extension also included a warning that any further extension would require congressional action. In turn, we appreciate U.S. Representative Schumer's efforts in September 1988 to introduce a bill that would address the INS limitation of a 1-year extension. As you know, Congressman Schumer's bill was enacted with changes to allow a 1-year extension to H-1 nurses whose time would expire.

Today, we wish to support with qualification the follow-up proposed legislation, H.R. 1507. The bill provides a prompt, permanent residence to foreign nurses who entered the United States with an H-1 status prior to 1988 to include a labor certification. But the bill does have the potential of reversing the very reason nurses entered the United States, which was to practice nursing in a hospital. By expediting the resident status of all nurses, their nursing jobs are no longer a condition of their employment, and the potential for losing those nurses exists.

We, including myself as a practitioner, are apprehensive about interjecting a third party—specifically, the Department of Labor—into a process that has served us well. In our naive way of thinking, it appears we need only to fine-tune previous legislation and remedy the INS decision to cap H-1 continuous stays.

The potential disruption factor becomes very real after we learned that certifications by the Department of Labor applicable

to H-2 workers and to third and sixth preference visa petitions for permanent residence are notoriously difficult to process, can cause major delays, and are unpredictable in result.

The proposed certification implies that our member hospitals use H-1 visas in lieu of recruiting and retaining American nurses, which is an implication that is without fact or merit. Also, the fact that each hospital must certify annually will only result in hospitals concentrating on an unwarranted process instead of patient care.

Our nursing shortage is very real. Our third annual demand study shows the percentage of vacant positions increasing, not decreasing. Can we not reasonably look at legislation that would allow immigrants in professional occupations to have easier options of remaining in the United States? Can we not seek labor certification on a national basis rather than each hospital in a metropolitan area?

H.R. 1507 is a start in the right direction. Our emergency rooms are crowded, or they are closing because staffing is in critically short supply. The Fort Worth Star Telegram editorialized about the critical situation when Fort Worth had no emergency trauma care available during a holiday weekend.

We don't need white papers to tell us a nursing shortage exists. We don't need study groups scheduling endless numbers of hearings to tell us what the white papers revealed. We need a nurse that helps save a life in the emergency room, we need a nurse to remain with that patient in intensive care where life hangs in the balance, and we need a nurse to care for that patient as he or she recovers until the day of discharge.

Again, thank you for the opportunity to discuss this subject important to 10,000 patients who are in our member hospitals at this very moment. Thank you.

Mr. MORRISON. Thank you, Ms. Bradshaw.

[The prepared statement of Ms. Bradshaw follows:]

PREPARED STATEMENT OF BEVERLY BRADSHAW, DALLAS-FORT WORTH HOSPITAL COUNCIL

The Dallas-Fort Worth Hospital Council (DFWHC), on behalf of its 80 institutional members, appreciates the opportunity to present this testimony before the subcommittee's hearing of May 31, 1989 regarding the proposed legislation to amend the Immigration and Nationality Act to provide for special immigrant status for certain H-1 nonimmigrant nurses to establish conditions for admission during a 5-year period for nurses to work as temporary workers. I am John C. Gavras, President of the Dallas-Fort Worth Hospital Council.

Background

The Dallas-Fort Worth Hospital Council discovered the beginning of the current nursing shortage in November 1986. Shortly thereafter a demand survey confirmed that as of December 31, 1986 we had 1,250 registered nurse positions available. That equates to 13% of the total positions available. In addition, a separate supply survey showed only 700 registered nurses (R.N.) would graduate from area schools.

In January 1987 a very active task force of human resource experts from our hospitals put into operation a twelve point program to recruit nursing students and address the crisis for the long term. The Healthcare Manpower Progress Summary Report - 1988 is included as an addendum to this testimony. It documents our successes for the past two plus years.

In the midst of our many activities, we learned that 70 nurses in the Dallas-Fort Worth metroplex had H-1 visas due to expire within a two year period of time. At the same time, we learned the INS proposed to cap H-1 continuous stays at five years. This proposed action would instantaneously add another 6% to our vacancy rate.

We appreciated the INS response in June 1988 granting a sixth year extension. The extension also included a warning that any further extension would require congressional action.

In turn we appreciate U.S. Representative Schumer's efforts in September 1988 to introduce a bill that would address the INS limitation of a one year extension. As you know, Congressman Schumer's bill was enacted with changes to allow a one-year extension to H-1 nurses whose time would expire.

Today we wish to support with qualifications the follow up proposed legislation, H.R. 1507. The bill provides a prompt permanent residence to foreign nurses who entered the U.S. with an H-1 status prior to 1988 to include a labor certification.

But the bill has the potential of reversing the very reason nurses entered the U.S., to wit, to practice nursing in a hospital. By expediting the residence status of all nurses, their nursing jobs are no longer a condition of their employment and the potential for losing those nurses exists.

We are apprehensive about interjecting a third party, specifically the Labor Department, into a process that has served us well. In our naive way of thinking, it appears we need only to fine tune previous legislation and remedy the INS decision to cap H-1 continuous stays.

The potential disruption factor becomes very real after we learn that certifications by the Department of Labor applicable to H-2 workers and to third and sixth preference visa petitions for permanent residence are "notoriously difficult to process, cause major delays, and are unpredictable in result."

The proposed certification process implies that our member hospitals use H-1 visas in lieu of recruiting American nurses which is an implication without fact or merit. Also the fact that each hospital must certify annually will only result in hospitals concentrating on an unwarranted process instead of patient care.

Our nursing shortage is very real. Our third annual demand study shows the percentage of vacant positions increasing, not decreasing. Can we not reasonably look at legislation that would allow immigrants in professional occupations to have easier options of remaining in the U.S.?

Can we not seek labor certification on a national basis rather than each hospital in a metropolitan area?

H.R. 1507 is a start in the right direction. Our emergency rooms are crowded or they are closing because staffing is in critically short supply. The Fort Worth Star Telegram editorialized about the critical situation when Fort Worth had no emergency trauma care available during a holiday weekend.

We don't need white papers to tell us a nursing shortage exists. We don't need study groups scheduling endless numbers of hearings to tell us what the white papers revealed. We need a nurse that helps save a life in the emergency room; we need a nurse to remain with that patient in intensive care where life hangs in the balance; and we need a nurse to care for that patient as he/she recovers, until the day of discharge.

Thank you for this opportunity to discuss a subject important to 10,000 patients who are in our member hospitals at this very moment.



Dallas-Fort Worth Hospital Council

John C. Gavras, President

Healthcare Manpower Progress Report - 1988

Healthcare Opportunities Brochure

A 68-page, color recruitment brochure was created and used by hospital recruiters to attract healthcare professionals to the Dallas-Fort Worth area. The publication details benefits and specialties of over 50 member hospitals, as well as a list of professional associations and licensure organizations. Two response cards are included in each brochure to request further information. An initial order of 10,000 copies have been distributed at job fairs throughout Texas and the United States, sent to nursing schools in the United States and Canada, provided to Metroplex libraries as a resource and direct mailed to individuals requesting information. In 1989, the brochure will continue to be disseminated at job fairs, mailed to areas where hospitals have closed, and provided to all college placement centers.

Scholarship Referral Service

A list of scholarships and tuition assistance offered by area hospitals and other healthcare organizations is a great source of information to high school counselors and students. In 1989, this list will be direct mailed to high school counselors, distributed to students through the Adopt-A-School program, and readily made available to college advisors, as well as anyone contacting the Council for information.

Co-op Advertising with Community College

A collaborative effort has been very successful in increasing nursing and respiratory therapy enrollment. As a result of advertising campaigns, the DCCCD and TCJC are putting students on waiting lists to enroll in the ADN program. Plans for '89 include running ad campaigns for respiratory therapy programs and concentrating efforts to increase the enrollment capacity for the ADN programs. The Council will also be trending enrollment and graduation data so that we can predict the number of graduates given enrollment by semester.

Adopt-A-School Program

The Adopt-A-School program has grown to include 29 hospitals and 34 high schools, involving over 55,000 students. In 1988, hospital employees participated in the program by attending career days, assisting health careers classes in taking their blood pressures, hosting health careers contests, providing guest speakers for classes, forming health careers clubs, giving hospital tours, tutoring, speaking at PTA meetings, educating and supporting troubled youth, forming "mini-mentorships", and even playing in a staff-faculty football game! Plans for 1989 include increasing the number of hospitals and schools involved, as well as resources for hospitals and students. The Council also plans to develop a computerized tracking system in which students expressing an interest in health careers can be sent information on a periodic basis.

"Counselor/Teacher of the Year" Award

In the fall of 1988, the Council developed guidelines for an award to be presented to the high school career counselor or teacher that has done the most to promote health careers. This award will be presented in May of each year, and will include an all-expense paid trip to their annual professional workshop in Santa Fe, New Mexico. Two awards will be given — one in Dallas County and one in Tarrant County.

Middle School Essay Contests

In a pilot project the Council sponsored a health careers essay contest for eighth grade students in Dallas County. All contestants were given an assignment to organize and present, in written form, an essay on a specific health career. In May of 1988, the Council presented 18 eighth grade DISD students with \$200 savings bonds for their winning compositions. In 1989, the Council will extend the contest to include Fort Worth Independent School District.

Demand and Supply Audits

In 1986, the Council first conducted an audit of our members' current and projected healthcare manpower requirements to the year 1991. From this survey we were able to anticipate future trends in demand and develop strategies to mitigate shortages. Although the Demand Audit details vacancies for the Metroplex, its concept and information has received national and international attention. The audit is updated annually and the new audit with projections to 1993 will be completed in February of 1989.

A Supply Audit was conducted for the first time in 1988. This survey was sent to all local colleges and universities with healthcare programs inquiring as to current and expected enrollment over the next five years. When matched with the Demand Audit, it will pinpoint areas of shortages where there is not adequate local supply. This survey will be completed in April of 1989.

Salary Surveys

The Council internally conducts four separate salary surveys — the Benchmark Staff Salary Survey, the Psychiatric Salary Survey, the Personnel Salary Survey, and a management compensation survey. The Benchmark is done on a semi-annual basis, and the Psych and Personnel surveys are done annually. In 1988, a turnover survey was conducted by Ernst & Whinney and results will be reported in '89.

Public Service Announcements

In 1988, the Council had the privilege of working with The Richards Group, a local advertising firm, to produce public service announcements focusing on nursing and other careers in the healthcare professions. In 1989, the Council will begin airing these PSA's on the radio, with the Council's metro phone number given to call for more information.

El Centro Student Nurse Survey

A survey was given to all nursing students at El Centro to gather information for marketing PSA's and advertising. Questions were asked regarding favorite radio stations, newspapers, selection of nursing career, and problems hindering completion of program. The majority listed inadequate financial aid as being a possible barrier to graduation.

Loan Forgiveness Program

Beginning in 1989, the Council will propose guidelines that hospitals can adopt or modify regarding a type of financial aid. Basically, a hospital provides the student with money for tuition if the student agrees to work for a period of time (usually one year) at the hospital. If the student fulfills the obligation, the loan is "forgiven". If for some reason the student does not fulfill the obligation, the student is required to pay the hospital the amount of money borrowed.

Healthcare Programs Brochure

In 1989, the Council will create a brochure which details health careers, academic prerequisites for each career, and the location(s) in the North Texas area where the program is offered. The pamphlet will be in an easy-to-use matrix format and will be distributed to counselors and students. This will tie in well with the PSA's, metro phone number, and scholarship referral service.

Mr. MORRISON. Mr. Cooper.

**STATEMENT OF STEPHEN COOPER, VICE PRESIDENT, THE
HOSPITAL ASSOCIATION OF NEW YORK STATE**

Mr. COOPER. Thank you.

My name is Stephen Cooper, vice president of the Hospital Association of New York State.

Last week, there was a strike at St. Luke's Roosevelt Hospital in New York City. The hundreds of nurses, the R.N.'s, striking said, "This is not a strike about money, this is a strike about staff shortages. This is a strike about working overtime, working weekends, and working evenings."

At least once a week in every paper across the country there is an article about the nurse shortage. It is everywhere. It is throughout the United States. The help wanted ads are filled with advertisements for nurses.

Nursing is a very difficult job. It is emotionally draining, it is physically draining, stressful, and, compared to a lot of other professions, it is not very well paid. It is not surprising that we are facing a shortage of nurses.

The shortage of nurses has taken its toll on hospitals and it has taken its toll on patients. Half of the hospitals in New York have had to deny admissions for nonemergency services. One-quarter of the hospitals have diverted patients that needed care on an emergency basis, and 15 percent of the hospitals have closed entire units.

Let me tell you what that means in real terms. Let me tell you what it means when we talk about a nonemergency case. If we talk about a patient who needs chemotherapy because they have cancer and say, "I'm sorry, you can't come in today; maybe next week," well, if that was your mother, or your father, or your child, you'd start saying, "Wait, this is an emergency." But for the hospital who has no nurses and whose beds are filled, it's not an emergency, it will wait.

The nursing shortage is real, and there is no evidence to suggest that it is going away. Well, I have to start by saying that foreign nurses are not the long-term solution to our nursing shortage, but, nonetheless, they do provide short-term relief, and without foreign nurses many of our hospitals simply won't be able to provide care.

I believe that H.R. 1507 is important to American nurses, I believe it is important to the patient, and I believe it is important to our hospitals in general. Without foreign nurses, our already over-extended nurses work force would be unable to cope. Without the assistance that these nurses offer, many nurses would simply leave nursing and say, "The hell with this, I'm going to a less stressful job and a less demanding job."

I will skip all my statistics out of my report, because you have heard them a hundred times already, and I won't tell you about the supply of nurses and the shortage of nurses; I'm getting tired of hearing it.

Let me just say that the shortage of nurses has taken its toll on nurses, and I hear this every day—and I'll divert from my text—that nurses are starting to burn out. Nurses are working long

hours, very long hours, and they are saying to me, "We need these nurses on the floor. I don't care if they are foreign nurses; I don't care where they come from. Without these nurses, it means I'm going to work every weekend as opposed to every other weekend. It means I'm going to work every holiday as opposed to every third holiday." Foreign nurses are very important to us. They are a very important part of our nursing work force.

Let me tell you about some of the statistics about foreign nurses. Someone said before that foreign nurses only represented 1 percent of the nursing work force, and that is probably true, but that is not true everywhere. In New York State, it is very different. Let me tell you about New York City. In New York City, there are 34,000 nurses. Approximately, 8,900, or 26 percent, are foreign trained, and approximately half of those are here on temporary visas.

What we have—preliminary data suggest that 12 to 14 percent of the nurses in New York City are here on temporary visas. This is an average. That means that some hospitals have 25 percent foreign nurses, some hospitals have less. If a hospital loses 12, 13, or 20 percent of its nurses, it closes, it doesn't take in any more patients. Without foreign nurses, patient care would be seriously jeopardized.

We support the concepts embodied in H.R. 1507 and believe that it can be the vehicle for producing a temporary solution to our nursing crisis.

Thank you very much.

Mr. MORRISON. Thank you, Mr. Cooper.

[The prepared statement of Mr. Cooper follows:]

Statement Presented By

Stephen H. Cooper
Vice President
Hospital Association of New York State

My name is Stephen Cooper, Vice President of the Hospital Association of New York State. On behalf of over 275 hospitals in New York State, I thank you for the opportunity to present our testimony on H.R. 1507.

An article in the Tuesday, May 23, 1989, New York Times began "Hundreds of registered nurses struck St. Luke's-Roosevelt Hospital Center in Manhattan yesterday in a dispute over what they called rising staff shortages and nursing workloads that have eroded patient care ..." A spokeswoman for the nurses said, "This strike is not about money."

An article in the Monday, May 22, 1989, New York Times describes the life of a nurse. (The) "job begins at 7:30 a.m. Patients with severe diarrhea must be cleaned constantly. Some, stricken with dementia, repeatedly tear their respirators loose. Others must be restrained to keep them from wandering around out of the hospital...When all seems done at her patient's bedside, there is always the paperwork."

These articles are not atypical. At least once a week in every newspaper across the country there is a story about the shortage of nurses and what hospitals are doing about it. Every day the "Help Wanted" section is filled with dozens of advertisements for nurses.

Nursing is a difficult job. It is emotionally draining, physically demanding, stressful and, compared to many other professions, not very well-paid. It is not surprising that hospitals are facing a severe shortage of nurses.

The shortage of nurses has taken its toll on hospitals. Half of the hospitals in New York have had to deny admissions for non-emergency services because of the nursing shortage, one quarter of hospitals have diverted patients that needed care to other facilities, 15% of the hospitals have had to close entire units.

The nursing shortage is real and there is no evidence to even suggest that it is going to disappear soon. H.R. 1507 recognizes the real problems hospitals face in trying to provide health care. We support the concepts embodied in H.R. 1507 and believe that the Congress can no longer delay addressing this critical issue.

I must also state that foreign nurses are not the long term solution to the nursing shortage. Nonetheless, they do provide the short term relief necessary while we develop more permanent solutions. Without foreign nurses, we would be unable to provide care.

I believe that H.R. 1507 is important to American nurses. In many areas and in many hospitals, foreign nurses are a significant part of the work force. Without foreign nurses, our already over-extended nurses would be unable to cope. Without the assistance that foreign nurses offer, many nurses would simply leave nursing for less stressful and less physically demanding jobs.

The Shortage of Nurses - The Statistics

Hospitals in New York State and across the nation are facing a serious labor shortage and the demand for nurses is increasing faster than the supply.

The Demand for Nurses

It is not uncommon for hospitals to report 10% to 11% RN vacancy rates with higher rates in critical care and emergency units. Hospitals need more nurses than they used to. The nature of the hospital patient population has changed. The average patient is older and sicker. Patients who would have been admitted to the hospital five years ago are now treated outside of the hospital or in the hospital's outpatient department. One large teaching hospital in New York recently reported 40% of all surgeries are now performed in the hospital's outpatient department, compared to less than 10% only five years ago.

The patients who are admitted to hospitals require more nursing care. This problem is particularly severe in large metropolitan areas. In New York City and elsewhere, hospitals and their nurses must confront a growing number of AIDS patients, a growing number of patients suffering from drug and alcohol abuse, a growing homeless population with multiple health problems, and a growing number of elderly with little or no family or community support.

This is reflected in the ratio of nurses to patients. In 1983, there were 80.8 nurses for each 100 hospital patients. By 1987, there were 97.8 nurses for each 100 patients.

The Supply of Nurses

In absolute terms, the supply of nurses has increased. In 1980, there were 1.66 million registered nurses in the United States. By 1987, there were 2.03 million nurses. Moreover, most nurses are working. In 1970, 70% of all RNs were employed in nursing; by 1988, 80% of nurses were employed. A growing number of nurses are employed full time. In 1977, 47% of all RNs were employed full time; by 1988, that number increased to 54%. The proportion of nurses working in hospitals has not changed. In both 1977 and 1988, 68% of all nurses worked in hospitals.

The future supply of nurses is questionable. Poor professional image, occupational stress, low earning potential, and increased opportunities for women in other areas have made nursing a less attractive career choice for many women. Between 1980 and 1987, the number of nurses enrolled in nursing programs has dropped by 30%.

Staff Nurses "Burning Out"

The shortage of nurses has taken its toll on working nurses. Staff nurses, in short supply and under siege from the extraordinary needs of acutely ill patients, are "burning out." As fewer and fewer staff nurses want to remain on the hospital floor, burnout increases.

A recent study by the Commonwealth Fund, a New York-based foundation, found that one out of four registered nurses in New York City will move to a new job every year. Many experienced nurses have given up on full time hospital jobs and now work full time for temporary agencies. The rapid loss of veteran staff members throws hospital floors into disarray, putting increased pressure on existing staff and making it more difficult to attract new nurses.

Hospital administrators are left with the task of convincing the remaining nurses to work overtime. Long hours have taken their toll on patient care. One nurse commented, "You have days when you are so tired you can't see straight."

Hospital administrators who rely on nurses from temporary agencies have other worries. Temporary nurses are unfamiliar with hospital procedures, especially emergency procedures. In order to ensure patient safety, hospitals have limited the types of tasks temporary nurses can undertake. Full time staff nurses often resent temporary nurses who earn more than they do and who have less responsibility.

A Solution?

Most experts agree that there is little prospect of a quick fix. The outlook for the future is not particularly bright. There are two demographic trends working against any short term solution; the aging of the population and a long term decrease in the college age population.

Yet, most experts also agree that unless we take some measures to protect our nursing work force, many nurses will desert the bedside for other nursing jobs or for other professions.

Foreign Nurses

Foreign nurses are an important part of the supply of nurses in New York and elsewhere. In New York City, there are approximately 34,000 registered nurses. Approximately 8,900, or 26%, of these nurses are foreign trained and approximately one-half of these nurses are here on temporary visas. Preliminary data suggests that between 12% and 14% of all nurses working in hospitals in New York City are here on temporary visas.

Without foreign nurses, patient care in our hospitals would be seriously jeopardized. Without foreign nurses, we would be making the jobs of our domestic nursing work force considerably more difficult. This is not an issue of taking jobs from American workers, or is it simply an issue of salary. Foreign nurses are essential to our existing work force.

Yet, the current process for recruiting qualified foreign nurses is time consuming, expensive and cumbersome. We believe that current procedures to recruit qualified foreign nurses must be streamlined and the process must be expedited. We support the concepts embodied in H.R. 1507 and believe that it can be the vehicle for producing a temporary solution to our nursing crisis.

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ADDENDUM - H.R. 1507Section 2 - Special Immigrant Status for Certain H.1
Non-Immigrant NursesGeneral

We agree with the intent and provisions of this Section. We do not believe that Section 2 represents an amnesty program. While an amnesty program grants special immigrant status, the benefit of this special status accrues primarily to those receiving this status. The benefit of granting special immigrant status to foreign nurses accrues primarily to hospital patients and to the existing domestic work force. A loss of these nurses would create a severe hardship for the remaining nursing work force.

Specific

Section 101(a)(27)(J)(i). The entry date should be changed from January 1, 1988 to January 1, 1989.

Section 3 - Requirements for Admission of Non-Immigrant Nurses
During a Five-Year Period

General

We believe that the intent of this Section is to expedite classification and recruitment of non-immigrant nurses and to establish several safeguards. The safeguards generally fall into one of two categories. The first establishes minimum professional standards for foreign nurses intending to practice professional nursing in this country. The second ensures that the hospital compensates foreign nurses at a rate that is no less than the prevailing wage for nurses employed by the facility and that the facility is not seeking to employ foreign nurses to influence or circumvent the legitimate bargaining representative. In general, we agree with these safeguards.

However, we are concerned that in its implementation, the process outlined in this bill may unintentionally delay the classification and recruitment of foreign nurses. The proposed language allows the administrative agencies substantial latitude in defining standards and the processes for reviewing applications. We believe that the statutory language should provide greater specificity and time frames for completing such reviews.

Specific

Section 212(m)(2)(A) and (B) - We believe that the phrase contained within Paragraph (A), a "substantial disruption ... in the delivery of services without the services of such alien" is vague and would be difficult to implement. Oftentimes, hospitals employ several hundred nurses and it would be difficult for a hospital to demonstrate that the failure to obtain a single nurse would cause a substantial disruption in the delivery of health services. We believe that the standard contained in this Section should be amended to embody the concept of a significant hardship in providing health services without the services of such alien or aliens.

Section 212(m)(2)(B) allows hospitals in urban areas to meet the condition outlined in paragraph (A) if the Secretary of Labor determines that the urban area has a significant shortage of nurses. We believe that this section unfairly penalizes rural hospitals and should be amended to include any area able to demonstrate a significant shortage of nurses.

We believe that the statute should establish guidelines for the Secretary of Labor outlining the criteria for determining what constitutes a significant shortage of registered nurses. At a minimum the Secretary should address vacancy rates, the inability of hospitals to open or maintain the operations of some health services, the inability of hospitals to attract registered nurses to specialized units, such as AIDS units or critical care units, the number of times hospitals must defer admissions because they lack adequate staff, or the number of times hospitals must route emergency cases to other facilities because they lack adequate staff in their emergency rooms.

Mr. MORRISON. Mr. Clark.

STATEMENT OF IRA CLARK, JACKSON MEMORIAL HOSPITAL,
MIAMI, FL

Mr. CLARK. Mr. Chairman, thank you.

I've sat through all three panels, and I think as the only active practicing hospital manager that has been on any of the panels, I have tried to order some thoughts in my head that would not be redundant and perhaps would address some of the things from the standpoint of hospital management that you heard before.

I have been actively involved in hospital administration for 25 years. I have directed three of the five largest hospitals in the country, including one on the perimeter of Congressman Schumer's district; that was at King's County Hospital for 12 years, I directed Bellevue in Manhattan for 3 years, and of course I now direct Jackson Memorial Hospital of the University of Miami Medical Center in Miami, and I must tell you, throughout that significant time period I have yet to see the hospital or to meet the hospital CEO who ever wanted to have foreign nurses.

To the extent that any hospital has foreign nurses, they are doing so to try to address a need that they are experiencing in an admittedly imperfect way. They simply feel that that is the only alternative that they have to make a bad situation better.

I have yet to meet anyone who thinks that whatever percentage of reliance that they have on foreign nurses is a long-term solution to the problem either in their institution or in the health care delivery system in general, and I think that needs to be said.

Third, what I have not heard throughout all of the testimony that you have taken this morning is issues that have to do with the foreign nurses themselves. There is no question that they provide a tremendous service in the institution—in the various institutions where they are employed. I think some of the things that are embodied in H.R. 1507 and the companion bill are things that are simply equitable and just for them, that they have been earned by them on the basis of the quality and the quantity of services that they have provided that, in their absence, wouldn't have gotten provided.

The second generic area I wanted to address with you very briefly is from the unique perspective of the public hospital, the large hospital in the large urban areas of America, particularly the teaching institutions, of which there are probably 30 or 35, and they are perhaps the signal example of institutions who, by their very nature, are forced by circumstances completely beyond their control to rely inordinately on foreign nurses. They are unique institutions, and by these I mean the King's Counties, and the Jacksons, and the Bellevues, and the Los Angeles Generals, and the Cuyahogas, and the Cook Counties, and the charities in New Orleans. They are in every quadrant of our country.

Why are they unique? First of all, they are unique in the context of some of the things that you have heard in that they don't get to choose their missions, they don't get to choose the kinds of services that they provide on the basis of profitability, of the desirability of the clientele, or to match it with the strengths of their medical

staff. They simply have to do those things that everyone else in their region is either unwilling or incapable of doing, and in most cases those things are inordinately expensive, they involve clientele that the rest of society generally perceives as being undesirable, whether these be drug addicts or alcoholics or street people or AIDS victims or prisoners, whoever they are.

Sometimes it is just a matter of sheer economics. Level three neonatal care is very expensive. The care for severe burns is very expensive. These are the kinds of product lines that hospitals who are in positions, generally private hospitals, can opt out of. These same kinds of services require very, very expensive nurse coverage, and they don't just require it on the day tour, they require it 21 tours a week, that is 3 shifts, 7 days.

So when you start to build the need for nursing hours around those kinds of uncontrollable circumstances, it doesn't become difficult to understand that you have to try to obtain those nursing hours wherever you can get them and from foreign sources where that is the only option available to you.

There is no question that the conceptual basis of both bills, 1507 and its companion bill, is both just and appropriate. They are not long-term solutions, but they are things that would be helpful both to the providers and to the foreign providers of care, and we support those things enthusiastically.

I would challenge the committee, particularly—I was particularly interested and animated by the dialog that went on between the chairman and the representative of the Secretary, and the issue is that there are some very significant things that need to be done long term to try to address this problem in a way that everybody would be comfortable with. One of those issues has to do with changing the image and the rewards that are associated with a nursing career.

I think one thing that is overlooked, this class of hospitals that I have addressed, by and large, are not located in very attractive locations in the principal cities of America, and that alone becomes an impediment to American nurses working there in many cases.

One of the things that could be very helpful in that regard is safe, attractive, and affordable housing, particularly for what I call baby nurses, for the new nursing graduates who can live on campus and work these off tours where they are so urgently needed in critical care units. That would also be of value to the foreign nurse in respect of those kinds of things. The kinds of things that you have generally heard about scholarships, about wage rates, and about all those things that would make nursing more appealing in the future is something that is appealing equally and not inconsistent but, indeed, is complementary with the intent, as I understand it, of H.R. 1507 and H.R. 2111.

Thank you.

Mr. MORRISON. Thank you very much.

Ms. McEachen.

STATEMENT OF IRENE McEACHEN, VICE PRESIDENT FOR NURSING, BETH ISRAEL MEDICAL CENTER, ACCOMPANIED BY SUSAN WALTMAN, GENERAL COUNSEL, GREATER NEW YORK HOSPITAL ASSOCIATION

Ms. McEACHEN. Good afternoon, and thank you very much for inviting me here to testify before this panel.

I'm Irene McEachen, the vice president for nursing at Beth Israel Medical Center, a 934-bed acute care hospital in Lower Manhattan. I am accompanied by Susan Waltman, general counsel for the Greater New York Hospital Association, and without once again going over many statistics and many comments that have been made heretofore this morning, I think what comes through loudly and clearly to all of us is that the nursing shortage is not a problem with one nexus of coming into being, it is multifaceted, and as we look to solve the nursing shortage we are not going to find one solution that will totally take it away, but we must look at many things, put them all together, complete the puzzle, and therefore improve the numbers of nurses and the retention of nurses in our hospitals.

In New York City, we have some special problems that have been addressed by others, and certainly our Medical Center faces some of the same instances. We look very clearly to our recruitment and retention of staff, and we have some unique, I think, parts of our organization that maybe are not so common throughout the country.

Beth Israel Medical Center has a school of nursing. It has been in place for 85 years, and we very actively recruit students into the school. We take our mission to go to the high schools of New York and to project the positive image of nursing very seriously and do that as a stepping stone to increasing our enrollment in our school of nursing.

We do the usual things that hospitals do in terms of an open house—competitive salaries, fair practices for our staff, et cetera—and in looking to our own school of nursing we have a very generous loan forgiveness program so that students can attend the school of nursing and not go into serious and, indeed, have all of their debt relinquished if they stay with Beth Israel for 2 years.

Throughout the city, the Greater New York Hospital Association is working closely with its member hospitals on a project called Ladders in Nursing Careers. This LINK program is very specifically looking at those persons who are already in our system of health care, perhaps in some other line of work, not a nurse, not an LPN necessarily, but working as a transporter or someone in the lab or someone in the pharmacy, and earmarking those persons to move into the nursing profession by providing them with scholarships. So we are very much looking at our own talented in-house pool to encourage them to complete an education in nursing and therefore fill some of our vacancies.

In recruitment into nursing, I think everyone is very actively looking at what some of us call the three M's—that is, midcareer persons, men, and minorities—and the Greater New York Hospital Association and Project LINK is looking at this as well with this very creative response to our shortage.

At this point in time, I would say that the departure of foreign trained nurses would be a devastating blow to the city of New York in terms of numbers of staff that we have available to us for all the reasons that you have heard from others here this afternoon, and I feel at this point some one of us should be speaking for those of us who are least able to speak for ourselves, and by that I mean the neonates who are in our intensive care neonatal units and the frail elderly who currently, this very day, need care.

The long-term solution may not be with us on this table before us today, but part of the solution is to retain our foreign nurses who bring expertise, compassion, and many talents to our patients. So, on behalf of our patients, I really urge you to think through this bill and to be supportive of it.

We really do have a nursing shortage that is very severe. As indicated, we have concerns as to the imposition of conditions on new entrants in terms of this bill because of the delays that might occur as well as the possibility of restrictive interpretations with respect to those conditions.

But I thank you for the opportunity to appear before you all, and I wish you to think this through very carefully with all you have heard today.

Thank you.

Mr. MORRISON. Thank you very much.

[The prepared statement of Ms. McEachen follows:]

TESTIMONY OF
 IRENE McEACHEN, VICE PRESIDENT, NURSING
 BETH ISRAEL MEDICAL CENTER
 NEW YORK, NEW YORK
 ACCOMPANIED BY
 SUSAN C. WALTMAN, GENERAL COUNSEL
 THE GREATER NEW YORK HOSPITAL ASSOCIATION

BEFORE THE SUBCOMMITTEE
 ON IMMIGRATION, REFUGEES, AND
 INTERNATIONAL LAW
 ON THE
 PROFESSIONAL NURSING SHORTAGE
 AND H-1 VISAS
 MAY 31, 1989

Good Morning. My name is Irene McEachen, and I am the Vice President for Nursing at the Beth Israel Medical Center in New York City, which operates a 934 bed medical center in lower Manhattan as well as an extensive network of methadone maintenance treatment programs with approximately 1,260,000 outpatient visits per year. I am accompanied today by Susan C. Waltman, General Counsel of the Greater New York Hospital Association. The Association represents the interests of 111 voluntary, not for profit hospitals and long term care facilities in New York City and surrounding communities.

We would like to thank you for the opportunity to testify today and more particularly for your efforts in trying to find ways to alleviate the nation's very severe nursing shortage. In this regard, we thank you not only for your efforts with respect to the Immigration Nursing Relief Act that is before us today but also with respect to your past efforts, which resulted in the current moratorium on the expiration of H-1 visas of professional nurses already working in the United States. Without your activities, we would be facing a professional nursing crisis that would be even more devastating to the delivery of health care than the one currently before us.

While I am appearing before you as a spokesperson for Beth Israel Medical Center and to address the problems that we are facing and will face in the future, I will also speak on behalf of Beth Israel's sister facilities in the New York City area that are undergoing the same, if not greater, problems as a result of this dilemma. For this reason, my testimony will not only address the impact of this problem on Beth Israel but will also provide you with an overview of the situation facing all of us.

THE SHORTAGE

New York's Shortage of Nurses

While the nursing shortage is a nationwide phenomenon, it is particularly acute in the New York City area. At Beth Israel, we had, as of March 31, 1989, a 20 percent vacancy rate for our professional or registered nurses (RNs). This vacancy rate continues to be high notwithstanding our use of per diem or registry nurses and our current reliance on foreign trained nurses. In actual numbers, this means that we have 228 vacant RN positions.

On a Citywide basis, a recent study of the nursing shortage in New York City, undertaken by the Greater New York Hospital Foundation, Inc., with support from the New York Community Trust and Citicorp, found that there is an average RN vacancy rate of 15% for hospitals and 25% for nursing homes. This vacancy rate translates into an immediate demand for at least 5,000 RNs Citywide.

The effects of these shortages are significant. Shortages of nursing personnel have been a significant factor in the current overcrowding of hospitals and the emergency room backlogs that have plagued New York's health care system for almost two years. Their most devastating effects are seen in the ability of hospitals to open additional beds and to keep currently certified capacity staffed for service. A survey conducted by the New York State Department of Health in January, 1989, found 1,088 beds out of service Citywide, chiefly due to staffing shortages. At the time of that same survey, occupancy of available medical/surgical beds was at 95.4%. The addition of staff is essential to expanding the capacity of hospitals and long term care facilities to address the increasing needs of the elderly, patients with AIDS, and all individuals who require medical care.

The effects are being demonstrated in a very tangible way at this very moment: St. Luke's-Roosevelt Hospital Center, which, with 1,315 beds, is among the nation's largest medical centers, has transferred almost one-half of its patients and been on diversion from the City's Emergency Medical Services System as a result of a strike by its nurses. According to the unions, the nurses are striking not because of pay or other economic factors, but because of inadequate staffing levels, the demands made of the nurses due to the current nursing shortage, and their fears as to how this might affect patient care.

It should be noted that salaries for nurses in the New York City area have been escalating rapidly in the last year. Today, the average starting salary for nurses is over \$30,000, and recent settlements by several major institutions in the City are likely to boost this figure even higher in the coming months. Eventually, we expect that such salary increases will have a favorable impact on the supply of nurses. Unfortunately, however, these wage increases are higher than annual Medicare and State reimbursement rate adjustments, and a great portion of these new expenses, therefore, goes unreimbursed.

The Shortage from a Broader Perspective

However, it should be noted that the RN shortage is not the only personnel shortage facing health care facilities today, which means reliance on other groups of professionals or occupations to supplement or alleviate the demands for RNs becomes almost impossible. In a press release, dated May 3, 1989, the American Hospital Association (AHA) announced the results of a recent AHA survey, which concludes that access to hospital care is being threatened by current personnel shortages. According to the AHA, "despite adding overtime, changing compensation programs, setting up on-call staff pools, and using contract services, one-fourth of hospitals responding to the survey were forced to cut services, more than 15 percent closed beds or units and almost 13 percent sent patients to other hospitals because they lacked sufficient staff."

New York State's situation is no different. In a report dated January, 1989, the New York State Labor-Health Industry Task Force on Health Personnel described the crisis in New York in this way:

".....current shortages of health workers are threatening the very foundation of health services. Shortages have reduced access, leading to a form of unintentional rationing and may be reducing the quality of care for those receiving services . . . Current shortages are leading the health care system into a vicious cycle as increasing frustration and burnout lead to increased departures, which in turn place additional burdens on the remaining work place and discourage new workers."

The report identifies a multitude of complex reasons why the shortages are occurring, including:

- o The "changing demographics" of the population as a whole, which is resulting in an increasing proportion of elderly (who require more health care services) and a decreasing proportion of younger people (who could be channeled into the caregiving professions);
- o The increase in the number and types of career opportunities available to women, a group that has long provided a very significant portion of the health care services delivered;
- o The lack of a coordinated planning mechanism among the primary players in the equation: the providers, the educators, and the trainers; and
- o The increased focus on credentialling in the face of limited access of many to specialized training programs.

A recent study has confirmed that New York City facilities are significantly understaffed in a number of key personnel categories, including RN and licensed practical nurse (LPN) categories. In the study, which was sponsored by GNYHA and conducted by New York University's Health Research Program, GNYHA set out to identify and compare staffing ratios in certain job categories between hospitals in New York City and hospitals outside of New York State. Thirty-two GNYHA member hospitals were surveyed and 15 hospitals in 10 cities elsewhere in the United States responded to the survey instrument.

A table from that study is found below. As the table is reviewed, it should be kept in mind that the comparison is between New York and national staffing ratios, which in certain categories, according to the AHA, are already low nationwide and causing service cutbacks. Consequently, the table demonstrates that while the nation is suffering from a health care worker shortage, New York may be even harder hit.

**Personnel Per 100 Census For
Nursing and Support Staff**

	<u>New York</u>	<u>National</u>	<u>% Difference</u> (Natl/NY)
RNs	88.00	98.00	11%
LPNs	10.00	22.00	120%
<hr/>			
Nurse Att./Orderlies ¹	24.80	12.69	NY Higher
Messengers	1.50	0.60	NY Higher
Dietary Aides ²	8.56	7.90	NY Higher
Escorts	1.93	3.06	59%
Clerks	7.03	13.80	96%
IV Teams	0.47	0.67	43%
Phlebotomists	1.37	2.70	97%
Central Supply	3.11	3.80	22%
Housekeepers	20.00	20.40	2%

NOTE: For support staff titles, staffing ratios are for all three shifts combined but excluding weekends.

SOURCE: RN and LPN data are for all New York City or all United States community hospitals; based on AHA Hospital Statistics, 1988. Support staff data are based on a survey of 32 New York City voluntary hospitals and 15 United States hospitals; survey conducted by the NYU Health Research Program.

¹ New York data exclude two hospitals, which did not report for this category.

² New York data exclude one hospital, which did not report for this category.

Of note is also the fact that, while it appears that hospitals in New York City have a much higher ratio of nursing attendants and orderlies than hospitals surveyed nationwide, this number must be taken in the overall context of the low RN and vastly lower LPN per 100 census ratios present in hospitals in New York City. It would appear that hospitals here have tried to compensate for deficiencies in their RN/LPN staffing by utilizing nursing attendants and orderlies.

Quite obviously the shortages are real, and they are affecting access and efficiency as evidenced by our demonstrably longer lengths of stay, our inability to open or to keep open needed services, and the concerns expressed by workers about our staffing levels. Although we do not believe that the quality of our care is being compromised, we are concerned that, as we go farther down this path, if nothing changes, we may be at risk for quality of care problems as well.

OUR CURRENT NEED FOR FOREIGN TRAINED NURSES

Beth Israel's Reliance on Foreign Trained Nurses

The foregoing picture of nursing and other personnel shortages in New York City includes foreign trained nurses and assumes the continued presence of all foreign nurses currently working in the United States as well as the continued ability to hire foreign nurses so long as the shortage continues. Should there be any interference with the ability of health care facilities to draw upon foreign trained nurses, at least for the next several years, the effects will be devastating.

At Beth Israel Medical Center, approximately 14 percent of the 837 salaried nurses currently employed came to us on H-1 visas. Of these, approximately 90-95 percent are from the Philippines. As of March 31, 1989, only 7 percent of these foreign trained nurses had obtained permanent residency. Of those 17 nurses who entered the U.S. prior to January, 1985, only 6 (or 35%) have obtained permanent residency.

It should be noted that the nurses on H-1 visas at Beth Israel tend to be concentrated in certain services and units and also tend to work during the evening and night shifts. For example, a large number of the nurses working in Beth Israel's intensive care and cardiac care units as well as on our medical and surgical services are here on H-1 visas. Additionally, these nurses tend to be further concentrated during the evening and night shifts.

At the risk of stating the obvious, the areas where there is the most significant risk of stress and burnout in the profession are the intensive care units and the medical/surgical services. Therefore, while every individual nurse is valuable, those working in these areas are virtually irreplaceable and of critical importance to our health care system.

The System's Reliance

Citywide, the situation is not different. In a study undertaken by the Greater New York Hospital Foundation, Inc. and published in December, 1988, it was found that 26.5 percent of nurses working Citywide are foreign trained. We have been informed that the number of foreign trained nurses working for the New York City Health and Hospitals Corporation is even greater: 28 percent.

On the basis of preliminary results of a second study undertaken by the Greater New York Hospital Association, it appears that, according to 41 institutions that have responded to GNYHA's survey thus far, 35 institutions now employ 2405 nurses who entered the U.S. on H-1 visas. Of this number, only 219 (or 9.1 percent) had obtained permanent residency as of March 31, 1989. The study, which GNYHA will be completing shortly, examines the number of nurses working on H-1 visas, where they are working, and what facilities would have to do should they be forced to leave. The following table reports the total number and number by date of entry of H-1 visa nurses in GNYHA member hospitals and long term care facilities for the 41 responding facilities.

Number of Nurses on H-1 Visas
GNYHA Member Facilities^{1,2}

<u>Entry Date</u>	<u>Total H-1 Visas</u>	<u>H-1 Visa Nurses Who Have Received Permanent Status</u>	
		<u>No#</u>	<u>Percent</u>
Before 1/1/85	570	81	14.2
1/1/85 - 12/31/85	203	33	16.3
1/1/86 - 12/31/86	244	18	7.4
1/1/87 - 12/31/87	474	56	11.8
1/1/88 - 12/31/88	697	29	4.2
Since 1/1/89	<u>217</u>	<u>2</u>	<u>.9</u>
Total	2405	219	9.1

¹ Preliminary data from a survey of H-1 visa nurses sponsored by Greater New York Hospital Association.

² Number of responding institutions = 41

Preliminary data from GNYHA's survey of H-1 visa nurses also shows the tremendous reliance that many facilities have on H-1 visa nurses in key units. The following table

indicates that H-1 visa nurses as a percentage of all nurses on a unit ranges from 15% in the emergency rooms to over 30% in ICUs, CCUs, and medical and surgical units.

**Utilization of H-1 Visa Nurses
in Selected Units¹**

<u>Unit</u>	<u>Number of Hospitals²</u>	<u>H-1 Visa Nurses as a % of Total Nurses Assigned to Unit</u>
Medicine	17	34.8
Surgery	15	33.1
Operating Room	18	16.4
Intensive Care Unit	13	30.7
Coronary Care Unit	9	32.2
Emergency Room	11	15.2

¹ Preliminary data from a survey of H-1 visa nurses sponsored by Greater New York Hospital Association.

² Includes hospitals with H-1 visa nurses assigned to unit and complete data concerning total nurses assigned to unit, by shift.

Finally, the following table shows for all H-1 visa nurses working on a particular hospital unit, the percent of such nurses who work evenings and nights. As this table reveals, H-1 visa nurses are heavily utilized during the non-daytime shifts.

**Percent of H-1 Visa Nurses Working
Evening and Nights on Hospital Units¹**

<u>Unit</u>	<u>% of H-1 Visa Nurses</u>
Medicine	84.5
Surgery	77.7
Operating Room	22.2
Recovery Room	59.4
Intensive Care Unit	76.7
Coronary Care Unit	64.5
Labor and Delivery	76.9
Postpartum	70.6
Pediatrics	91.8
Routine Nursery	46.7
Neonatal ICU	81.5
Psychiatry	50.0
Rehabilitation	70.0
Dialysis	69.6
Drug/Alcohol Detox	80.0
Emergency Room	71.4
Other Outpatient	0.0

¹ Preliminary data from a survey of H-1 visa nurses sponsored by Greater New York Hospital Association.

Effects of Their Departure: Curtailing Admissions and Elective Surgery

With approximately one out of every four of our City's nurses entering the country on H-1 visas and a high proportion of these nurses working in critical care areas, we clearly remain very reliant on foreign trained nurses. Should they be forced to return home or should the future supply be affected, at least for the time being, many institutions, including Beth Israel, would have to take drastic measures to counter the results. In planning for such a situation, should it occur, we have concluded that we would probably have to curtail admissions in general and elective surgery in particular. We also believe that we would have to increase the use of agency and per diem nurses to the extent that they are available, notwithstanding the fact that they are extremely expensive.

From preliminary data collected by GNYHA, facilities Citywide will have to undertake similar efforts should this occur. As part of its study, GNYHA asked its members to indicate how much hardship it would be for individual facilities if all H-1 visa nurses who entered the country before January 1, 1985, and who have not received permanent residency were required to leave the U.S. at the end of 1989. As the following table shows, a clear majority of institutions have indicated that this would pose extreme hardship.

Loss of H-1 Visa Nurses: Potential Impact to Institutions

<u>Degree of Hardship</u>	<u>Number of Institutions</u>
Extreme hardship	22
Some hardship	7
Little or no hardship	3

SOLVING THE PROBLEM: WHAT WE ARE DOING

There are no simple, one shot answers to a problem as complex as this one. The solution will take time and demands creativity and cooperative efforts. The recommendations made by the State Labor/Health Industry Task Force echo this statement. Each player in the delivery system, from government regulators, payers, and health care administrators to labor leaders, the professions, and individual workers, must be willing to examine their respective philosophies, roles, and requirements to see where creative, substantive changes can be made. The ultimate goal, however, must continue to be the provision of high quality health care to those in need.

Beth Israel's Recruitment Efforts: Aggressive, But A Local Solution Requires Long Term Goals

We, at Beth Israel, believe that we have undertaken very aggressive efforts to recruit and retain nurses locally. Our efforts to date include the following activities:

- o Beth Israel operates its own School of Nursing.
- o Each student who graduates from Beth Israel's School of Nursing and who undertakes to work for Beth Israel is extended a \$5,000 loan. If the nurse works for Beth Israel for two years, the loan is forgiven. Should the nurse's employment terminate within two years, the amount of the forgiveness is pro-rated.
- o Beth Israel is participating in GNYHA's Ladders in Nursing Careers (L.I.N.C.) Program, which provides opportunities for existing hospital workers to upgrade their positions. The program is explained in more detail in the next portion of our testimony.
- o Beth Israel advertises extensively in newspapers and journals at a cost of approximately \$300,000 per year. In addition, we post and distribute advertisements in unemployment offices, union halls, and other locations.
- o Existing employees are offered a \$500 bonus for referring nurses to us.
- o We are in the process of developing a matrix model of unit management that hopefully will free our registered nurses from certain clerical and other responsibilities.
- o We attempt to offer competitive salaries with appropriate increments based on experience and education.
- o Beth Israel participates extensively in job fairs and career days. We also conduct several open houses each year.

- o We attempt to retain our current nurses by showcasing their accomplishments, providing them with more autonomy and independence, and offering continuing education programs to promote professional growth and direction.
- o We provide presentations at area schools and educational institutions at all levels in an attempt to attract more individuals to the practice of health care in general.

We believe that we expend substantial efforts in attempting to recruit locally, and yet, notwithstanding our efforts, we continue to have a significant vacancy rate. Consequently, it is critical for us to be able to retain the experienced foreign nurses who are currently working for us as well as to be able to continue to recruit outside of the United States.

What We Do Citywide

- o Project L.I.N.C.—Ladders in Nursing Careers

In describing local recruitment efforts, I would like to spend a few moments describing two very promising programs that have been undertaken by the Greater New York Hospital Association. The first program is called Project L.I.N.C. (Ladders in Nursing Careers) and is a program that provides educational advancement opportunities for individuals already working in hospitals and nursing homes who are in entry or mid-level jobs (e.g., nursing attendants, licensed practical nurses, ward clerks, etc.).

Individuals enrolling in the program attend school full-time while working part-time at the sponsoring institution. In order to prevent loss of income while pursuing studies, students participate in a loan/service payback arrangement. Under this program the sponsoring institution provides a forgivable loan of \$8,000 per year of training or two-fifths of the base salary, whichever is greater, each year the participant is in the program. Pension and medical benefits are continued in full. Other work related benefits are pro-rated according to the actual amount of time worked. Finally, the sponsoring institution arranges course-compatible work schedules to facilitate classroom instruction. In exchange, participants are required to work at least two days a week and fulfill a service payback obligation of 18 months continuous full time service for each one year loan.

Project L.I.N.C. consists of five consortia (one per Borough) made up of hospitals and long term care facilities that are members of GNYHA and local nursing schools. Currently, over 40 hospitals and long term care facilities and 20 schools of nursing have agreed to participate. Each school participating is required to have the mechanism for determining proficiency and providing advanced placement in pre-nursing/nursing courses. The intent is to assure that participants will be given credit for existing skills and knowledge and will not be required to take courses that repeat prior learning.

Each consortium has or will have a consortium administrator/educational counselor whose responsibility will be to conduct diagnostic assessments, provide personal and educational counseling, assist in school application procedures, identify the need and make arrangements for remediation, assist in determining eligibility for advance placement, and conduct other implementation activities.

Participants from the first consortium began classes in January, 1989; the other consortia are now in the implementation process with approximately half of the facilities aiming for enrollment in September, 1989, and the remainder aiming for enrollment in January, 1990.

The individuals for whom Project L.I.N.C. has been designed are currently working in hospitals and nursing homes and, by definition, are well acquainted with the nursing profession. Consequently, there is a high likelihood that these individuals, once upgraded, will remain in nursing for a significant period of time. Additionally, many of these individuals are known to want to upgrade. Typically, from low income, disadvantaged backgrounds, however, they have been unable to do so due to financial, educational, social or other barriers. Project L.I.N.C. is designed to eliminate these barriers.

There is a great deal of interest in this program among employees in GNYHA's member hospitals and nursing homes. Last Fall, for example, when the program was piloted in seven hospitals and nursing homes in the Bronx and upper Manhattan, nearly 500 people applied. As the program is implemented in institutions throughout the rest of the City over the next few months, the number of applicants is expected to approach 2,000. While not all of these people would immediately qualify for admission to a school of nursing, it is estimated that at least one-quarter would qualify. Resources permitting, the Association is hoping to enroll up to 300 people by the end of the year.

o **Health Care Careers Center**

In further recognition of the crippling effects that the shortages of nurses and other allied health personnel are having on the operations of hospitals and long term care facilities, GNYHA and the League of Voluntary Hospitals and Homes have been working together to develop strategies for eliminating shortages of health personnel. In this regard, these two organizations have joined together in the establishment of a health care careers center, the purpose of which will be to carry out a coordinated, aggressive, broad set of initiatives aimed at increasing the supply of health professionals.

The center is being established as a separate tax exempt entity with a) a governing board consisting of executives from GNYHA and League members facilities and b) an advisory committee consisting of both technical experts from member facilities as well as representatives from key public and private organizations whose participation will be essential to the center's success (e.g., City University of New York, State University of New York, State Health Department, State Education Department, New York City Board of Education, etc.).

The central purpose of the careers center will be to expand the existing supply of health personnel, focusing on major occupational shortages including nursing. The immediate goals of the careers center will be to fill every health occupation training program in New York City and surrounding communities and to serve as a catalyst for establishing new programs or expanding existing ones where current capacity is determined to be insufficient to meet the industry's needs. Among other activities, the center will maintain an up-to-date coordinated data base for job vacancies and educational/training openings, conduct major marketing and advertising campaigns, operate a telephone referral hotline, and serve as a clearinghouse for information about health occupations.

ONE WAY TO ADDRESS THE CRISIS: DON'T INTERFERE WITH ABILITY TO EMPLOY FOREIGN TRAINED NURSES WHILE SHORTAGE CONTINUES

We at Beth Israel, together with other facilities in New York City, believe that our efforts and the foregoing programs have an excellent chance of resolving the nursing shortage in the long run. But these solutions are clearly long term ones, and they will

take time to show results. In the meantime, however, it is critical that nothing occur to make the crisis worse because our health care system cannot tolerate any further stresses, particularly in the form of increased personnel shortages. As providers, we are currently doing what we can with what we have, and we believe we are doing it well. But we are seriously concerned that any further reductions in personnel will seriously affect our ability to deliver quality care.

The Need for Either Legislative or Administrative Action to Avoid Disruption in Service Delivery

For these reasons, although it is expensive and not necessarily the most ideal alternative, we are forced to recruit professional nurses from outside the United States in order to enable us to continue to provide care, in many cases in connection with our most critically needed and critically oriented services. Any actions that would cause foreign nurses, particularly those who are the most experienced and the most familiar with our systems, to have to return home at this point would be disastrous. In addition, any efforts that would make it more difficult for new entrants to come to the United States, at least for the duration of the nursing shortage, would cripple health care in certain areas of the country.

Consequently, we welcome your efforts to extend the periods during which professional nurses on H-1 visas may stay in the United States both by postponing the expiration of their visas and/or by extending these nurses special immigrant status in order to solve their individual problems on a more permanent basis. We believe that this will not only assist those who might be precluded from obtaining permanent residency because they come from countries that have extraordinarily long waiting periods for obtaining permanent residency but also encourage those who might not have been contemplating permanent residency because of resulting limitations on their ability to travel home to visit family to stay in the United States. Our only comments with respect to this aspect of the bill is that the benefits afforded should extend to all nurses in the United States as of the effective date of the bill rather than to only those in the U.S. as of January 1, 1988.

Concerns about Conditions on New Entrants

We are concerned, however, about the imposition of conditions on new entrants for at least a five year period. While the elimination of the immigration problems for those

nurses who are already here will avoid further exacerbation of the nursing shortage, we continue to be, at least for the time being, very dependent on a continuing supply of new foreign nurses. As indicated previously, even with these foreign nurses we are facing severe shortages. Consequently, any actions that will inhibit or retard our ability to hire qualified professional nurses from other countries in the future will make matters worse.

For this reason, we believe that the creation of a new classification of non-immigrant nurses for a five year period could have serious negative consequences if the conditions, which appear, on their face, to be quite fair, are interpreted narrowly and the regulatory apparatus designed to judge the conditions is not prepared to process applications quickly. Therefore, we strongly urge that you take into account the following recommendations in considering such a program:

- o **The Need for a Fully Operational Approval Process** – The new classification and its attendant conditions should not become operative until the regulatory mechanism designed to address new applicants is fully operational.
- o **The Need for an Expeditious Process** – The process for addressing the applications should be as streamlined as possible. In this regard, we recommend that a specific time limit be placed on the processing of the applications. For informational purposes, we point out that we have been informed that it currently takes 30 days to process an application for an H-1 visa nurse.
- o **Reliance on Department of Labor's Blanket Certification** – With respect to the specific conditions, we have concerns about the condition that requires a facility to demonstrate that there would be a "substantial disruption through no fault of the facility in the delivery of health care services of the facility without the services of such an alien." We understand that the proposed legislation deems that this condition has been met if the Secretary of Labor determines that a facility located in an urban area has a significant shortage of registered nurses. However, we question whether this determination is necessary given that the Secretary of Labor has already determined

that professional nurses are habitually in short supply in the United States and therefore qualify for a blanket labor certification.

While we understand that the intent of this new condition is to demonstrate that the nurses being brought into the United States are critically necessary, we believe that the Department of Labor's blanket labor certification, taken together with the other conditions proposed by the bill, adequately protect domestic nurses. Further, we point out that there is a very clear incentive both financially and operationally for facilities to recruit locally as opposed to abroad. There is always a risk that the foreign nurses will want to return home and substantial expenditures are incurred for identifying and bringing these individuals into the United States in the first place.

- o **The Need for a Liberal Administrative Interpretation** - We believe that the remaining conditions are quite fair, but again we have concerns as to how they will be interpreted from an administrative standpoint once the new classification is operational. Therefore, to the extent possible, it would be helpful to generate legislative history that indicates that the intent is not to restrict the entry of professional nurses in the future so long as there is a nursing shortage and facilities are attempting to recruit locally.

CONCLUSION

In summary, our nursing shortage is severe, and we cannot increase our vacancy rates any further without cutting back on the services that we deliver. We, therefore, support your attempts to avoid further exacerbation of the problem by granting special immigrant status to foreign nurses currently in the United States. As indicated, however, we do have concerns as to the imposition of conditions on new entrants both because of the delays that might occur as well as the possibility of restrictive interpretations with respect to the conditions. To the extent that these issues can be addressed, we believe it will greatly improve upon our ability to respond to the current shortage. We thank you for the opportunity to appear before you and for your efforts in connection with this issue.

Mr. MORRISON. Mr. Clark and Ms. McEachen, I'd like you to comment on the portion of Dr. Gibbons' testimony that suggested that a misallocation of job responsibilities is an important part of the nursing shortage, and that seems particularly directed to both of you.

Mr. CLARK. I'd be glad to, Mr. Chairman.

I could have included that among my generic rubric of "never having seen before." Again, there is no hospital that does not want to have adequate support services. There is no hospital that consciously, as a management strategy, determines that it is in anyone's interest to have highly trained professional nurses doing menial work. What that is is a reaction to the overall financial imperfect system that we have.

When I left Florida, the Florida Legislature was in session dealing with Medicaid policy, dealing with the specific issue of Medicaid disproportionate share. The senate—the Florida Senate had only in its appropriations bill the federally mandated minimum, which is \$850,000 statewide. Florida is now the fourth most populous State in the country. Now if that holds—and we hope that it won't; there is something more generous on the House side, but that is what they are in conference about—clearly, they will meet somewhere in the middle, but Jackson Memorial will have about a \$7 million hole in its operating budget in the upcoming year. That means we will have to lay off people. I assure you, we will not lay off registered nurses. What we will lay off are the very kinds of support people that you have heard characterized in that way today. So that is the way that thing comes about.

Nurses are the glue that holds the whole system together. It is like public hospitals. Because someone makes a policy determination or makes a financial judgment that takes away the wherewithal or the resources that are necessary to do an optimal job in the hospital setting, the need doesn't go away. What happens is, it gets addressed in an imperfect and an inefficient manner, so that if a patient has to get transported somewhere or if there is a menial task on the nursing unit that has to get done, and if there is no one there to provide that, particularly on off tours, on evenings and nights, the nurse is the one who does it, not by design but by abdication.

Ms. McEACHEN. I might just add also that there are many things that happened in the past that are no longer happening in the current practices, and it seems to me that at one point in time perhaps we had hospitals that were inefficiently using the skills of nurses, but as I move from hospital to hospital in New York City, that seemingly is less frequently happening.

Certainly at Beth Israel Medical Center, we have the support services. We do not misutilize nurses in terms of transporting patients and doing all the other clerical work that unit clerks do, et cetera.

So I think at one point in time it was very valid to say nurses run in and do everything, but at this point, because of the shortage, nurses are very much being pinpointed to the areas of their skills, and it also follows that with the severity of illness, as was mentioned before, with neonatal ICU's and burn units, nurses are needed to nurse, and we really see less and less misuse of them. So

I don't find that in my own medical center or in others that I visit in New York City.

Mr. MORRISON. Mr. Smith.

Mr. SMITH of Texas. Thank you, Mr. Chairman.

Mr. Sponseller, let me go to your testimony where you say that "the rural hospitals need to be included in the overall picture. Rural hospitals frequently have more severe recruitment problems than do large metropolitan areas." I agree with that. I have seen it firsthand. My question is, what do we do about it? How do we target the rural areas?

Mr. SPONSELLER. I think, as I have suggested in my written testimony, that we—that rural hospitals be included, rural areas be included, as eligible for a geographic certification of that type of certification as retained in the bill.

Mr. SMITH of Texas. So you would favor a geographic certification within the bills that we are discussing today?

Mr. SPONSELLER. We would like not to see a geographic certification. We would like to see the current national certification be considered sufficient, but if a geographic certification is going to be retained we think it needs to be beyond—the possibility of it needs to be beyond metropolitan areas and include rural.

Mr. SMITH of Texas. Why wouldn't you support a geographic certification, given the fact that you said that rural areas have more severe recruitment problems? How do you propose to solve the problem if you don't target the area?

Mr. SPONSELLER. Well, I think we can rely on the fact that there is a national problem and not have to go through the process of any geographic—

Mr. SMITH of Texas. That really doesn't answer the question. My question is, if you have an area that has a more severe shortage than another area, unless you target that area, are you really going to ever solve that area's problem of a nurse shortage?

Mr. SPONSELLER. Yes, those areas need to be targeted. I wouldn't disagree with that.

Mr. SMITH of Texas. I thought you were disagreeing. OK. That answered my question. Thank you.

Ms. McEachen, let me ask you a couple of questions. First of all, you have talked about the crisis in New York City. What percentage of nurses in New York City are foreign?

Ms. McEACHEN. Well, it can range from approximately 10 percent at some hospitals to as high as 26 percent in the New York Health and Hospitals Corp.

Mr. SMITH of Texas. So it varies from 10 to 26 percent. So far, more than the overall average of 1 percent.

Ms. McEACHEN. Yes.

Mr. SMITH of Texas. And that is why the dramatic impact. OK.

You mentioned in your testimony that salaries have been escalating rapidly in New York City. The average starting salary for nurses is over \$30,000. But then you talk about, "Unfortunately, these wage increases are higher than annual Medicare and State reimbursement rate adjustments. A great proportion of these new expenses, therefore, go unreimbursed." It makes me wonder if we are really going to solve the problem by raising nurses' salaries,

and what do you think the solution is? If raising salaries and improving conditions isn't the solution, what is the solution?

Ms. McEACHEN. As I said earlier, I don't think there is one solution. I think raising salaries and improving conditions is part of the solution. But if I was to look at the position of health care today from a consumer's point of view, which I do, I think it is a societal issue, and I think people across the board in society are going to have to come to grips with the cost of health care, what they are willing to pay for, and accept less than optimal care if they are unwilling to pay for it.

So everything has a price, and there isn't one solution to our problem, but I think the country and the people in this country make the determination as to where our money goes, so to speak, and we must look at health care and see where is it on our priorities.

Mr. SMITH of Texas. You favor kind of an overall approach whereby we would have more foreign nurses, higher salaries, better conditions, and spend more on health care then?

Ms. McEACHEN. I do indeed, personally. That's exactly—I think there are many, many facets that have to be addressed, and it can't just be a one-sided "pay nurses more." That won't do it. Bring in more foreign nurses; that won't do it. It is a global picture, and it requires a true global solution.

Mr. SMITH of Texas. Good point.

Thank you, Mr. Chairman. I don't have any other questions. Thank you.

Mr. MORRISON. Mr. Schumer.

Mr. SCHUMER. Thank you, Mr. Chairman.

First, let me thank all the witnesses for all their excellent testimony.

I must say, it is a surprise to see you, Mr. Clark. You did such a good job at King's County for so long, and Miami's gain is our loss.

Mr. CLARK. Half of Brooklyn is in Miami, Mr. Schumer.

Mr. SCHUMER. Yes, I know. I said if redistricting ever occurs, I'd go down to Fort Lauderdale and represent the same people.

Mr. CLARK. You'd win in a landslide.

Mr. SCHUMER. Also, Ms. McEachen, it's nice to have you here. You probably don't know, but I had a daughter born at your hospital 8 weeks ago tomorrow.

Ms. McEACHEN. I do know, and I checked on her daily.

Mr. SCHUMER. Oh, did you?

Mr. SMITH of Texas. I'd like to know if that means that Members of Congress will be receiving special influence or special consideration.

Mr. MORRISON. The question is, was that a gift, and do you have a direct interest in legislation?

[Laughter.]

Ms. McEACHEN. I absolutely do.

Mr. MORRISON. Mr. Schumer, put that on your form.

Mr. SCHUMER. "Special care for little baby."

Mr. MORRISON. You had better not run for a leadership position.

Mr. SCHUMER. Right, exactly.

OK. Anyway, I guess the position of really everybody, a few without equivocation, a few with some changes they would like, is support of H.R. 1507.

I just wanted to clarify, particularly Ms. Bradshaw, who, I'd say, had the most equivocation, I guess, if it is H.R. 1507 or simply just giving another 1-year extension of the H-1 program, which do you choose?

Ms. BRADSHAW. 1507.

Mr. SCHUMER. OK. Could you tell why? because I think that is important. Just for the record, it has taken us a long time to negotiate H.R. 1507 so that it would pass. We have had the folks from the hospitals, the folks from the unions, and everybody else involved, and not everyone got everything they wanted.

I guess the one thing I would say before you answer your question, Ms. Bradshaw, is, I just do want to assure the witnesses here that the idea of the bill is to not create obstacles to the abilities of hospitals to recruit foreign labor where you can demonstrate the need.

In other words, if we can assure that the intent of the bill is to require you to make a good faith showing of conditions under the H-4 program, would you still have some doubts? You know, in other words, you made a good faith show when you filed the paper, and that was that. Your worry is that it will just take forever to have these papers processed.

Ms. BRADSHAW. It would just be administratively cumbersome.

Mr. SCHUMER. OK.

Ms. BRADSHAW. Depending upon the process that was utilized and the amount of information needed to provide a good faith effort, it may be acceptable, but if it becomes a cumbersome process, then it would not be.

Mr. SCHUMER. Does anyone disagree with that summation by Ms. Bradshaw?

OK. Again, I am going to quit while I'm ahead. Thank you, Mr. Chairman.

Mr. MORRISON. Thank you.

I want to thank you all for your testimony and for your patience.

Our next panel will be Katherine Abelson, vice president of Local 1199, RWDSU in New York; Robert Guthrie, assistant director, Department for Professional Employees, AFL-CIO; Jerome Brown, president of the New England Health Care Workers District 1199; and Stuart Appelbaum, RWDSU, New York.

Would you all remain standing and please raise your right hand.

[Witnesses sworn.]

Mr. MORRISON. Please be seated. Thank you for appearing here today.

Your written statements will be included in the record, and, once again, we would appreciate your respecting the 5-minute period to summarize your testimony, and we will start with Ms. Abelson.

STATEMENT OF KATHERINE ABELSON, VICE PRESIDENT, LOCAL 1199, RETAIL, WHOLESALE & DEPARTMENT STORE UNION, NEW YORK, NY

Ms. ABELSON. Yes. I am Katherine Abelson, executive vice president for Local 1199 in New York City and, I might also add, a graduate of Mr. Clark's school of nursing in King's County and an alumnus of Ms. McEachen's obstetric unit in Beth Israel, where I myself was born a zillion years ago.

Mr. SCHUMER. Did you get special treatment?

[Laughter.]

Ms. ABELSON. I'm sure I did.

Mr. MORRISON. You get the small world award for that.

Ms. ABELSON. You might get more info out of my mother.

I appreciate the opportunity to address this commission today.

Mr. Morrison, your questions to the first panelists, I believe, painted quite a picture of our health care system, which was returned almost a decade ago to a free market system, one that promised efficient, quality care at greatly reduced costs and instead gave us, I can certainly vouch in New York City, a staggering health care crisis symptomized by a total lack of planning, decreased access to care for large segments of our community, increased acuity as people postpone care until they are really sick, little to no prenatal care leading to increased cost of neonatal intensive care, and an infant mortality rate that rivals the Third World, acute shortages not only in nursing but in other skilled health personnel, and, P.S., the whole thing is costing this Nation; the costs of health care have gone through the roof.

And that's the macropicture, and the micro we are here to deal with today really takes a couple of small measures toward redressing a gravely flawed system of health care, and I agree totally with the previous speaker that says we must as a society come to terms with providing and recognizing a societal responsibility to provide care for all our citizenry.

Foreign nurses have and continue to make a valuable contribution to that care. In New York, you have heard the figures. The problem was brought—and I think it is important that you know this—the problem was brought to our attention not by Philippine nurses but by American nurses who were looking at the specter of trying to cope with a system that already placed an inordinate and scary, frightening burden on them, trying to cope without these co-workers, and there is something very ludicrous in returning to the country of origin people who are experienced, licensed, acculturated, as has been depicted by a previous speaker. I fully agree, it is, once again, an irrational expenditure of our resources to return these people to country of origin, recruit yet another crop, reorient them at great expense, only to deport them down the future.

Now there may be those in the industry and in Government, as we have heard with the first panel of speakers, who might be content with granting one extension after another. These interim measures do not address the long-range solutions, and I believe Congressman Schumer's bill and Mr. Ackerman's bill—I am not testifying on Mr. Ackerman's bill, but both bills take a small step

in redressing that system that is so irrational in terms of planning for the health care needs of our population.

There are, however—and I need to add a couple of cautions. I've certainly spoken to Congressman Schumer about them. Ms. Lowery spoke to one, and that is that this does not cover nurses out of status, and they continue to work, and I have heard employers in my area say, "If you try to deport them, I will hide them"—said it right out on TV at Congressman Schumer's press conference. That was his hospital, his right, and his risk.

Nevertheless, they are here, they continue to work, they continue to provide a service, they are uncovered by this bill. I recognize that New York ain't the world. We're sometimes very arrogant about that in New York. Witness the New Yorker posters. But they should be covered by the provisions of this bill. They should be granted permanent residency.

Another caution. Agencies in New York City, the great majority of them, pay greater than market rates. I have encountered in small number in New York—and I understand it is a grave problem in California—the crop of agencies that recruit abroad, paying less than market rates, for these nurses to work alongside American nurses. This, in fact, would exacerbate the shortages that we see, and I think we need to address and shore up provisions of this bill or perhaps design another one that speaks to that problem and not allow exploitative agencies to flourish as industry, hospitals, seek to—and some will, and some won't—as some hospitals seek to avoid the labor certification difficulties presented by this bill.

Thank you.

Mr. MORRISON. Thank you very much.

[The prepared statement of Ms. Abelson follows:]

TESTIMONY OF KATHERINE ABELSON
EXECUTIVE VICE PRESIDENT,
LOCAL 1199 DRUG, HOSPITAL AND
HEALTH CARE EMPLOYEES UNION/RNDSU/AFL-CIO
BEFORE THE HOUSE SUBCOMMITTEE
ON IMMIGRATION
RELATED TO PASSAGE OF H.R. 1507

The 1199 League of Registered Nurses represents 4,000 nurses in 21 institutions in New York's greater metropolitan area. Approximately 850 of these R.N.s are here on H1 visas. The bulk of these nurses arrived in 1983 and 1984 and have had their visas extended.

Their plight was first brought to our attention by American R.N.s at one of our institutions. Six Filipino R.N.s had been terminated by an employer ignorant of IRCA provisions. (That employer has since become an ardent advocate of H.R. 1507). Our nurses were not only horrified by what they perceived to be abrupt and cruel treatment of these nurses, but also by the specter of trying to cope without them.*

* The Hospital Association of New York State (HANYS), the Greater Hospital Association of New York (GNYHA), and the New York City Health and Hospital Corporation (HHC) can provide data detailing the critical shortage of nurses throughout New York State, skyrocketing occupancy rates, increased levels of acuity and nurse vacancy rates. These organizations would be able to supply the sub-committee data on the numbers of nurses in New York on H1 visas and the number of these we would lose this year and next year should we fail to act legislatively.

The nursing shortage is a self perpetuating problem. The greater the shortages, the greater the burnout and exodus from the hospitals. Given current staffing levels, nurses are routinely working one or two double shifts per pay period. All too frequently, volunteers for overtime can't be found and nurses are mandated to stay.

It is perhaps difficult to comprehend, but when there is one RN for 24 patients -- two of whom may be on life support systems - - (formerly all such patients were treated in intensive care units where one RN seldom has more than three such patients and should have no more than two!), means that s/he must choose whom and what to neglect. Please understand that in such an atmosphere, errors are inevitable. Deaths, too, are inevitable. Observation and appropriate intervention are key to what nurses do. They cannot intervene appropriately when they haven't seen a patient since the shift began. The nurse chooses, appropriately, to tend the most acutely ill patients. S/he will not choose to tend to the relatively stable post-operative patient at risk of pulmonary emboli (blood clot in a vessel serving the lungs.)

Given current staffing levels, nurses live with the constant and not unreasonable fear that something they were not able to do, or an error they made, will have grave consequences for a patient

and for themselves. Their license to practice is in jeopardy.

If New York were to lose 5% or more of its nursing complement, neglect and mortality would accelerate and place an unconscionable strain on already overburdened U.S. nurses.

There are, perhaps, Congresspersons and some in the industry who would be satisfied with year to year extensions, but there are good reasons why such interim measures are not in this nation's best interest. I would like to address the reasons for passage of HR 1507 as opposed to simply granting one extension after another:

1. The industry currently spends a fortune on the short term solution of overseas recruitment. I suspect that this portion of most institutions' operating budget comes from public monies. This money would be better spent on providing a genuine career ladder or salary advancement for staff RN's, on the training and upgrading of health care personnel, and on the hiring of ancillary personnel (Aides, Orderlies, Ward Clerks, etc.) who could free up nurses to nurse.
2. An additional fortune is spent on the orientation of new RN's. It is illogical and costly to require experienced RN's to return home necessitating additional funds be spent on the recruitment and training of inexperienced replacements.
3. These overseas RN's, who have made and continue to make a considerable contribution to our medical and economic well-being, should not be penalized for industry and government's inability to attract and retain the skilled professionals our citizenry needs.
4. Furthermore, it defies reason that our I.N.S. is willing to extend amnesty and permanent residency

to qualifying immigrants who have been living here illegally since 1982 (appropriate, if inadequate legislation), while requiring RN's here legally since 1983 to leave the country.

5. It should go without saying that denying the immediate family of gainfully employed immigrants the right to join their loved one is cruel and inhuman, and contrasts starkly with all the hoopla over "family" touted by our current administration.
6. The structure of our immigrant regulations allows exploitative agencies to flourish. Unlike agencies employing U.S. citizens, which attract RN's with higher wages, these agencies employ overseas RN's who are ignorant of prevailing standards at lower wages. These agencies are then able to "sell" their RN's at discount rates to cost conscious institutions without any other conscience.

Lastly, the nurses from abroad have and continue to make an invaluable contribution to the well being of this nation. Granting them permanent residency is entirely in keeping with all past immigration policy, the bottom line of which has always been our own self-interest.

Let it be said of the 101st Congress that they took this (Passage of H.R. 1507) one small measure to promote long range solutions to the nursing shortage that so threatens the well-being of our citizenry.

Mr. MORRISON. Mr. Guthrie.

**STATEMENT OF ROBERT GUTHRIE, ASSISTANT DIRECTOR,
DEPARTMENT FOR PROFESSIONAL EMPLOYEES, AFL-CIO**

Mr. GUTHRIE. Thank you, Mr. Chairman.

I am Robert Guthrie, assistant director of the Department for Professional Employees of the AFL-CIO. I am here today to state our support for the Immigration Nursing Relief Act of 1989 introduced by Congressman Schumer for himself and a number of your colleagues.

There is no question but that the United States is in the grip of a severe shortage of registered nurses. In response, many health care facilities have turned to the employment of nonimmigrant alien nurses. We believe that this response has not only failed to solve the problem but has, in fact, exacerbated it by slowing wage growth for nurses, retarding improvement of their working conditions, and diminishing incentives for those facilities to recruit, train, and retain American nurses.

My printed statement excerpts from testimony presented to this subcommittee last year by an economist to the effect that we don't have a nursing shortage, rather, nurses are underpaid. She went on to say that using immigration to alleviate shortages in particular occupations is almost certain to hurt domestic workers employed in those same occupations because, as available research shows, immigration will hold down wage growth and possibly prevent improvements in working conditions. The New York City metropolitan area illustrates this. There, between 20 and 30 percent of the employed nurses are aliens admitted under the H-1 visa program.

While the nursing shortage there was developing in the year 1978 through 1985, our research shows that the wages of nurses there increased only 8 percent while the wages of nurses in three other metropolitan areas studied—San Francisco, Miami, and Los Angeles—increased 22, 19, and 12 percent, respectively.

We believe that H.R. 1507 is a well conceived response to the problems arising from the admission of nonimmigrant alien nurses to practice in the United States. The bill grants permanent resident status to those nonimmigrant alien nurses who would have acquired that status but for third and sixth preference backlogs for their country of origin. It establishes a 5-year pilot visa program for the admission of nonimmigrant alien nurses to practice here.

Under the pilot program, alien nurses would have to possess the same qualifications now required under the H-1 visa program, but, in addition, each health facility seeking to hire nonimmigrant alien nurses would have to meet requirements designed to assure that those nurses will not be used simply as an alternative labor supply or to undercut wages or working conditions, that the facility will end its employment of alien nurses as quickly as is reasonably possible by taking steps to recruit, train, and retain an adequate number of American nurses, and that alien nurses will not become pawns in labor disputes involving the institution.

None of these important safeguards apply in the existing H-1 visa program. Attachment C to my printed statement shows that

the INS has turned the H-1 visa program, which was intended for the admission of a limited number of aliens preeminent in their field, into an H-2 visa program without any tests or controls.

Booz, Allen & Hamilton, the management consultants who conducted a study of the H-1 visa program for the INS in 1988 concluded that, "The use of the H-1 program by employers to hire aliens at the entry or middle level, even in situations of labor shortage, such as in the case of nurses, is an inappropriate use of the program at variance with statutory intent."

It is evident that the H-1 visa program requires oversight and revision by Congress. We hope that this subcommittee and its Senate counterpart will soon undertake that process. As a first step, we urge that legislation be enacted to suspend the INS's pending H visa rulemaking proceeding until that revision is completed because the rules the INS proposes to adopt in that proceeding codify some of the same policies and procedures which have caused the H-1 visa program to depart from its statutory purpose.

My printed statement outlines how we would propose that the H-1 visa program should be revised. For the thousands of aliens now admitted under the H-1 visa program for whom that visa was not intended, we propose a visa program modeled on the provisions of H.R. 1507.

Thank you, Mr. Chairman.

Mr. MORRISON. Thank you very much.

[The prepared statement of Mr. Guthrie follows:]

STATEMENT
OF
ROBERT GUTHRIE, ASSISTANT DIRECTOR
DEPARTMENT FOR PROFESSIONAL EMPLOYEES, AFL-CIO

I am Robert Guthrie, Assistant Director of the Department for Professional Employees (DPE) of the AFL-CIO. I am here today to state the support of the DPE for the Immigration Nursing Relief Act of 1989, H.R. 1507, which Congressman Schumer introduced for himself and a number of your colleagues.

Before proceeding to discuss H.R. 1507, I would like to say a few words about the DPE. It is a constitutional department of the AFL-CIO comprised of 29 national and international unions (see Attachment A) which represent about three million professional and highly skilled technical workers, including a major portion of the unionized professional and technical workers in the health care field.

The DPE and several of its affiliates were among the organizations which began working with Congressman Schumer's staff in mid-1988 seeking to prevent the expulsion of the large number of registered nurses here on H-1 visas whose 5-year term of stay was expiring. This, of course, was when the shortage of registered nurses was becoming a matter of national concern, as it remains today. Those efforts led to the INS' recognizing the grave nature of the nursing shortage, granting those alien registered nurses here on expiring visas a sixth year of stay, and to legislation introduced by Congressman Schumer as H.R. 5239 in September of 1988. That legislation failed to win enactment in the closing days of the last Congress. Instead, section 4 of the Immigration Amendments of 1988 (Public Law 100-658) was enacted -- extending the visa status of registered nurses here on expiring H-1 visas through December 31, 1989.

H.R. 1507 which you are considering here today is in all major respects the same as its antecedent, H.R. 5239 of the 100th Congress.

There is no question that the United States is in the grip of a severe shortage of registered nurses. This shortage and the causes for it have been the subject of considerable study, and there seems to be general agreement that it has resulted from an increasing demand for the services of registered nurses at a time when the supply of those nurses is diminishing. Among the causes for the increasing demand are our aging population, with its greater need for health services, and the more intensive use of nurses in our health care delivery system. The diminishing supply of nurses is resulting from decreasing enrollments in our schools of nursing, and the abandonment of their profession by many nurses, both largely due to the poor working conditions to which nurses are subjected coupled with low pay and scant pay increases over a lifetime in the profession.

Given this nursing shortage, many American health care facilities have concluded that at least part of the solution lies in the employment of non-immigrant alien nurses. We believe that this response has not only failed to solve the problem but has in fact exacerbated it, by slowing wage growth for nurses, retarding improvement of their working conditions, and diminishing incentives for health care facilities to recruit, train, and retain American nurses.

As an economist testified to this Subcommittee last year:

The nursing profession is another example of an occupation in which domestic labor markets have not always worked very well to match demand and supply. In recent years, we have heard repeated complaints from hospitals about the shortage of nurses. But between 1983 and 1986, average weekly earnings of full time nurses, unadjusted for inflation, rose only 16 percent. (Over the same period, in spite of a perceived surplus of doctors, average weekly earnings of full time doctors rose 30 percent.) In a meaningful sense, we don't have a shortage of nurses; rather, nurses are underpaid.

* * * * *

A second lesson of the analysis I have sketched out is that using immigration to alleviate shortages in particular occupations is almost certain to hurt domestic workers employed in those same occupations. Under current law, labor certifications for immigration are supposed to be granted only where there are not sufficient United States workers who are able, willing, qualified and available to fill the jobs in question and where the wages and working conditions of United States workers similarly employed will not be adversely affected by the employment of aliens. Where any substantial number of immigrants in "shortage" occupations are allowed into the country, it is a fallacy to imagine that this condition can ever be satisfied...In the short run, immigration will hold down wage growth and possibly prevent improvements in working conditions that otherwise would have arisen in shortage occupations. Available research bears this out.¹

The New York City metropolitan area is a good illustration of this point. There, the nursing shortage is apparently as severe

¹Testimony of Katharine G. Abraham before the Subcommittee on July 12, 1987, pp. 4-5. Though the reference in the second segment of the quoted testimony is to the H-2 visa program, the points made apply as well to the H-1 visa program.

as it is anywhere in the nation. It is estimated that between 20 and 30 percent of the employed nurses in the NYC metropolitan area are aliens admitted under the H-1 visa program. Yet, as Attachment B indicates, for the years 1978-85 while the nursing shortage was developing, the wages of nurses in the NYC metropolitan area increased less than in any of the three other metropolitan areas studied (i.e., San Francisco, Miami, Los Angeles).

We believe that H.R. 1507 is a well-conceived response to the problems arising from the admission of non-immigrant alien nurses to practice in the United States.

First, the bill grants permanent resident status to those non-immigrant alien nurses who entered the U.S. prior to 1988 on H-1 visas which continue to be valid, if they continue to be employed as registered nurses and receive a labor certificate from the Department of Labor. Thus, they are accorded the permanent resident visa status acquired by most non-immigrant alien nurses on H-1 visas who sought it, but from which many of these nurses were foreclosed because of the backlogs in the third and sixth preference for their country of origin.

This grant of permanent resident status to these alien nurses under the bill will avoid a sudden worsening of the nurse shortage in hospitals heavily dependent on alien nurses which would also worsen the plight of the already overworked American nurses who now toil at their side.

H.R. 1507 also establishes a five-year pilot visa program for the admission of non-immigrant alien nurses to practice here.

During that five-year period, the H-1 visa program, with all of its attendant problems, would not apply to registered nurses.

Under the pilot visa program, non-immigrant alien registered nurses would have to meet the same standards now applicable under the H-1 visa program. That is, they would have to:

(1) be licensed to practice in the country where they received their nursing education, or have received that education in the U.S. or Canada;

(2) be licensed to practice in the state of intended practice or have passed the Commission on Graduates of Foreign Nursing Schools (CGFNS) examination; and

(3) be qualified under the laws applicable to the place of intended employment to practice at that place.

But, in addition to the requirements applicable to the non-immigrant nurse, each health facility petitioning for the admission of such nurses under the pilot program would have to establish to the Secretary of Labor's satisfaction that:

(1) without the services of the alien nurse there would be substantial disruption in the delivery of health care services by the facility, through no fault of the facility;

(2) there will be no adverse effect on the wages and working conditions of similarly-employed nurses, and the alien nurse will receive the prevailing wage for similarly-employed nurses at the facility;

(3) the facility is taking steps to recruit and retain American nurses in order to end as quickly as reasonably possible the dependence of the facility on the services of non-immigrant alien nurses;

(4) there is no strike or lockout at the facility and the employment of the alien nurse is not intended to affect an election for a bargaining representative at the facility; and

(5) notice of the filing of the visa petition has been given to the bargaining representative of the nurses at

the facility or, if there is none, to the nurses themselves.

These are the provisions that distinguish the pilot visa program of H.R. 1507 from the existing H-1 visa program. These requirements go a long way toward assuring that non-immigrant alien nurses will not be used as simply an alternative source of labor, or to undercut efforts to improve wages or working conditions. Health care facilities are required to wean themselves from dependence on non-immigrant alien nurses as quickly as is reasonably possible by being required to take steps to recruit and train an adequate number of American nurses. The provisions serve to assure that non-immigrant alien nurses will not become pawns in labor disputes involving the health facilities where they are employed. They also require that nurses employed by a facility receive some notice of the facility's intention to employ one or more non-immigrant alien nurses.

None of these important safeguards apply to the existing H-1 visa program.

The statutory basis for the H-1 visa program² provides that it applies to non-immigrant aliens "of distinguished merit and ability...coming temporarily to the United States to perform services of an exceptional nature requiring such merit and ability..." We believe that the use of the phrase "distinguished merit and ability" and the omission of any labor market test or

²Section 101(A)(15)(H)(i) of the Immigration and Nationality Act (8 U.S.C. 1101).

adverse wage impact determination, as is required for H-2 visas, is a clear-cut indication that those intended to be eligible for H-1 visas were a very limited number of aliens who were preeminent in their respective fields.

Instead, the INS in administering the H-1 visa program has turned it into an expedited substitute for the H-2 visa program, admitting nurses, musicians, actors, dancers, school teachers, computer programmers, and workers in numerous other occupations, of no particular merit or distinction, but without any labor market or adverse wage impact test. Attachment C illustrates what has happened as a result of the INS administration of the H-visa program. As you will note, in fiscal year 1970 there were over six times more non-immigrant aliens admitted on H-2 visas than on H-1s. By fiscal year 1988, this had been completely reversed, so that there were over three times the number of H-1 visa holders admitted as there were H-2Bs.

In this regard, the Booz, Allen & Hamilton firm of management consultants, which conducted a study of the H-1 visa program for the INS in 1988, concluded in its report to the INS:

Nonetheless, we believe that the use of the H-1 program by employers to hire aliens at the entry- or middle-level, even in situations of labor shortage, such as in the case of nurses, is an inappropriate use of the program, at variance with statutory intent.³

³Characteristics and Labor Market Impact of Persons Admitted Under the H-1 Program: Final Report, June 1988, by Booz, Allen & Hamilton, Management Consultants. However, as the attached Memorandum analyzing the Booz, Allen report makes clear, there are numerous findings and conclusions in that report with which we do not agree (see Attachment D).

It is evident that the H-1 visa program requires oversight and revision by the Congress. We hope that this Subcommittee, and its counterpart in the Senate, will soon undertake that process. As a first step, we urge that legislation be enacted to suspend the INS' pending H-visa rulemaking proceeding until that revision is completed. In its pending rulemaking, the INS proposes to adopt rules codifying some of the same policies and procedures which have caused the H-1 visa program to depart from its statutory purpose.

The H-visa rulemaking proceeding was begun in 1986 (51 Federal Register 28576-89, August 8, 1986). Amendments were adopted to the INS' appropriations for fiscal years 1988 and 1989 prohibiting the INS from adopting or implementing any final rule in the proceeding during those two fiscal years because of serious concern that the final rule would be inconsistent with Congress' intent and would not provide proper protection for American workers. The existing stay will terminate on September 30 of this year. We understand that the House and Senate Appropriations Committees, where the amendments providing these stays originated, believe that any further stays should be initiated in the House or Senate Judiciary Committee which have legislative jurisdiction over the INS. As I have already stated, we are hopeful that this Subcommittee will assume that initiative, since officials of the INS have made it clear that they intend to press ahead to a final rule in the H-visa rulemaking proceeding once the current stay is terminated.

As to the revision of the H-1 visa program, we believe the original purpose of the program is good public policy and should be retained. We propose that the H-1 visa category be limited to non-immigrant aliens (other than performing artists and other workers in the arts and entertainment industries) who have a high degree of learning and are preeminent in their field and are coming temporarily to the United States to perform services requiring such preeminence and learning.

Because of the special problems and circumstances which apply to them, a new H-visa category should be established for performing artists, performing companies, and workers in the arts and entertainment industries who are preeminent in their fields. Petitions for these new H-visas for work here in the arts and entertainment industries would be processed in a centralized INS facility under special procedures and guidelines to expedite processing and promote consistent decisionmaking.

For the great numbers of non-immigrant aliens who now receive H-1 visas, but for whom no claim could be made for preeminence, another new H-visa category should be established for which the provisions of H.R. 1507 would serve as a model.

With regard to the Emergency Nurse Shortage Relief Act of 1989, H.R. 2111, we support the goal of the legislation -- an increased supply of registered nurses. However, insofar as H.R. 2111 addresses non-immigrant alien registered nurses (section 7), we are opposed to its provisions because they contemplate that non-immigrant alien nurses will continue to be admitted into the United States under the existing H-1 visa program, and also because no provision is made for granting permanent residence to non-immigrant alien nurses, as is provided for in H.R. 1507.

AFFILIATES
OF
THE DEPARTMENT FOR PROFESSIONAL EMPLOYEES, AFL-CIO

Actors' Equity Association
 American Federation of Government Employees
 American Federation of Musicians
 American Federation of State, County and Municipal Employees
 American Federation of Teachers
 American Federation of Television and Radio Artists
 American Guild of Musical Artists
 Association of Theatrical Press Agents and Managers
 Communications Workers of America
 Federation of Professional Athletes
 International Alliance of Theatrical Stage Employes
 and Moving Picture Machine Operators
 International Association of Machinists & Aerospace Workers
 International Brotherhood of Electrical Workers
 International Federation of Professional and Technical Engineers
 International Ladies' Garment Workers' Union
 International Union of Electronic, Electrical,
 Salaried, Machine and Furniture Workers
 International Union of Operating Engineers
 International Union, United Automobile, Aerospace &
 Agricultural Implement Workers of America
 National Association of Broadcast Employees and Technicians
 National Union of Hospital & Health Care Employees
 Office and Professional Employees International Union
 Retail, Wholesale and Department Store Union
 Screen Actors Guild
 Seafarers International Union
 Service Employees International Union
 Transportation • Communications Union
 United Association of Journeymen and Apprentices of the Plumbing and
 Pipe Fitting Industry of the United States and Canada
 United Food & Commercial Workers International Union
 United Steelworkers of America

GENERAL DUTY NURSES
SELECTED YEARS AND METROPOLITAN AREAS

Hourly Earnings	NEW YORK			MIAMI			LOS ANGELES			SAN FRANCISCO		
	1978	1981	1985	1978	1981	1985	1978	1981	1985	1978	1981	1985
	\$7.59	\$9.36	\$12.70	\$6.52	--	\$11.76	\$7.69	\$11.05	\$13.33	\$8.70	\$11.88	\$15.52
Percent Change in Nominal Wage Rates	0.23	0.36	0.67	--	--	0.80	0.44	0.22	0.76	0.38	0.35	0.87
Percent Change in the CPI	0.35	--	0.59	0.41	--	0.61	0.43	--	0.64	0.46	--	0.65
Percent Real Wage Rate Change	-0.21	--	0.08	--	--	0.19	0.01	--	0.12	-0.08	--	0.22

PERCENT CHANGE IN REAL WAGE RATES
1978-1985, GENERAL DUTY NURSES

San Francisco	22%
Miami	19%
Los Angeles	12%
New York	8%

ATTACHMENT B

Prepared in August 1988 by the Department of Economic Research, AFL-CIO,
from data published by the United States Bureau of Labor Statistics.

NONIMMIGRANT ALIENS ADMITTED ON H-1 AND H-2 VISAS
FOR FISCAL YEARS:

	<u>1970</u>	<u>1973</u>	<u>1975</u>	<u>1978</u>	<u>1981</u>	<u>1982</u>	<u>1983</u>	<u>1984</u>	<u>1985</u>	<u>1986</u>	<u>1987</u>	<u>1988</u>
H-1 (Distinguished merit and ability)	11,096	15,670	15,550	16,838	na		39,944	42,473	47,322	54,426	65,461	73,771
H-2 (To perform services not available in U.S.)	69,288	37,343	37,460	22,832	na		29,514	23,362	24,544	28,014	25,557	20,675*
H-1 and H-2 (Not listed separately)						52,482						

* H-2B visa holders only (does not include agricultural workers)

ATTACHMENT C

Prepared in April 1989 by the Department for Professional Employees, AFL-CIO,
from data published by the United States Immigration and Naturalization Service.

ATTACHMENT D

AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS
815 Sixteenth Street, N.W., Washington, D. C. 20006

MEMORANDUM

Date: September 7, 1988

To: Jack Golodner, Director, Department for Professional Employees, AFL-CIO

From: Markley Roberts, Department of Economic Research, AFL-CIO *Markley Roberts*

Subject: Analysis of report by Booz, Allen & Hamilton, Inc., Management Consultants, on the H-1 Visa Program

This memorandum is in response to your request for an analysis of the study and report entitled Characteristics and Labor Market Impact of Persons Admitted Under the H-1 Program - Final Report, June 1988 which was done by Booz, Allen & Hamilton, Inc., management consultants, under a contract with the U.S. Immigration and Naturalization Service (INS).

In one very important respect the report confirms what the AFL-CIO and the Department for Professional Employees have long contended, that the H-1 visa program, as administered by the INS, is inconsistent with the provisions of section 101(a)(15)(H)(i) of the Immigration and Nationality Act, and with Congressional intent.

In the words of the report:

We do not believe that this use of the H-1 program corresponds to its original statutory intent.*

* * *

... many of the professional workers admitted under the H-1 program are employed in entry- or middle-level positions.

* * *

* Section 101(a)(15)(H)(i) of the Immigration and Nationality Act limits H-1 visa eligibility to any "...alien having a residence in a foreign country which he has no intention of abandoning (i) who is of distinguished merit and ability and who is coming temporarily to the United States to perform services of an exceptional nature requiring such merit and ability..."

... we believe that the use of the H-1 program by employers to hire aliens at the entry- or middle-level, even in situations of labor shortage, such as in the case of nurses, is an inappropriate use of the program, at variance with statutory intent.

(pages viii-ix)

The statement that "many" of the professional workers admitted under the H-1 program are entry- or middle-level employees rather than truly people of distinguished merit and ability is probably an understatement, since for some time the H-1 has been used to avoid use of the H-2 procedure, which Congress established to address labor shortages. Clearly an overwhelming preponderance of those admitted as H-1s do not qualify as distinguished or uniquely meritorious people. For example, with regard to nurses in the New York City area, the report finds that H-1 nurses currently account for between 20 and 30% of the area's total employment of nurses. Clearly such a large number is not what Congress had in mind when authoring the H-1 provision for people of "distinguished merit and ability".

As the report aptly points out, this distortion of the H-1 program has resulted in the public being misled as to the real purpose of the program and has created difficulties for the INS in administering the program and adjudicating petitions under it (p. viii).

To remedy this problem, Booz, Allen recommends a significant revision of INS policy and the H-1 provision. There is much merit in these recommendations. They deserve our careful consideration and the consideration of Congress. But the new H-visa rules which the INS is seeking to put into effect, after the present stay imposed by Congress expires on October 1 of this year, do not address the problems found by Booz, Allen and probably would further exacerbate the situation. The Booz, Allen study has uncovered a serious deficiency in the administration of the H-1 visa program, and has made recommendations

to correct it. Congress must address this. A continuance of the stay would give the Congress time to study the matter and avoid compounding the problems noted by Booz, Allen.

ADVERSE IMPACT

Having stated that the H-I provision has been mismanaged, the Booz, Allen study nevertheless alleges "that there is generally no adverse impact on employment of U.S. workers as a result of H-I admissions" (p. iv). In my judgment, a two-year sampling of data, which forms the basis for the Booz, Allen report, is not adequate for evaluating the interplay of supply and demand in the job market and provides an insufficient foundation for even such a carefully qualified statement.

Furthermore, the report raises more questions than it answers. For example, the report departs from accepted practice in that it uses wage and other data throughout without disclosing the source or sources of such data. Therefore, one must question whether the data used in all cases is representative or accurate, and whether conclusions reached can be substantiated.

The report states that 58,284 persons were approved for H-I status in FY 1987 (one of the two years studied) (p. II-1). Our information, verified by calls to the INS, is that the correct number is 65,461, a difference of over 12%! Why the discrepancy?

These and similar questions arise throughout the report. I will attempt to elucidate by reference to the two largest of the eight occupational groups studied in the report -- nurses and entertainers.

Nurses

Nurses are the second largest occupational group covered by the study. A major portion of the report is devoted to nurses, no doubt because of the national shortage of nurses which exists today. This shortage is particularly acute in the New York City area and the largest portion of the treatment of nurses is focused on New York. As noted above, the report estimates that from 20 to 30% of the nurses employed in the New York City labor market are nonimmigrant aliens admitted under the H-1 program (p. III-2). Given this large percentage and a rudimentary knowledge of supply and demand dynamics, one must assume that the presence of these H-1 nonimmigrants has had a negative effect on the job market for domestic nurses in New York, and on their salaries. And yet the report finds that the employment of nurses on H-1 visas in the New York City labor market has no adverse effect on American nurses. To reach such a conclusion in the face of all logic, the report should have presented an array of well-documented data dealing with the pay, working conditions, training and recruitment of nurses over a period of time longer than just two years. It does not do this. No explanation is given for the fact that a large number of trained RNs in the New York area do not now work as nurses; that the training of new nurses has not kept pace with demand; that salaries have not risen to attract trained RNs back into the field, or to encourage young people to enter it.

To make the finding of no adverse effect, the report first compares the wage levels of nurses generally in the New York City labor market with those of H-1 nurses (p. III-3). No source for any of this wage information is given. The wages of H-1 nurses are said to have been "\$11.63 in FY 1986, rising to \$12.43 in FY 1987". And according to the report, "These wage levels are similar to wages of nurses generally in this labor market area: according to information from various industry sources, in 1987, a base hourly rate of approximately \$12.00 to \$12.50 was 'typical' of nurses having two to three years work

experience." No further description of "various industry sources" is given, which leads me to believe that the conclusion is, at best, based on anecdotal information. But there are more serious questions regarding this conclusion which I will raise later.

The report goes on to discuss the "large presence of H-1 nurses in the New York City labor market area" (p.III-3) and whether in the absence of these nurses the prevailing wage rate for nurses would rise to a higher level. But with regard to this important question, it states, "We are not able to fully evaluate this possibility based on the data available to us."

The third leg of the report's argument for the proposition that the hiring of H-1 nurses does not have an adverse impact on American nurses is based on discussions with unidentified hospital representatives who apparently said that they sought to recruit and hire American nurses before alien nurses (pp. III-4, 5). I have no basis for disputing this assertion, but note that it does not prove the proposition. However, economic theory suggests that labor shortages will be met with higher salaries. The hospital representatives did not state that they offered higher salaries in their effort to recruit American nurses, even though that is the "classic economic response" to a labor shortage.

Finally, I call your attention to the following tables compiled from data published by the U.S. Bureau of Labor Statistics (BLS). (The base data is from an ongoing survey by the BLS of wages and related benefits in private, and state and local government hospitals for months in 1978, 1981, and 1985. Apparently, no BLS data was used in the Booz, Allen study and report.) Note that in New York, which the report cites as experiencing the heaviest use of H-1 nurses, the real wages of nurses increased at a rate far behind other cities. Could it be that the H-1 nurses did have an adverse effect on wages and,

GENERAL DUTY NURSES
SELECTED YEARS AND METROPOLITAN AREAS

Hourly Earnings	NEW YORK			MIAMI			LOS ANGELES			SAN FRANCISCO		
	1978	1981	1985	1978	1981	1985	1978	1981	1985	1978	1981	1985
	\$7.59	\$9.34	\$12.70	\$6.52	--	\$11.76	\$7.69	\$11.05	\$13.33	\$8.30	\$11.48	\$15.52
Percent Change in Nominal Wage Rates	NEW YORK			MIAMI			LOS ANGELES			SAN FRANCISCO		
	78-81	81-85	78-85	78-81	81-85	78-85	78-81	81-85	78-85	78-81	81-85	78-85
	0.23	0.36	0.67	--	--	0.80	0.44	0.22	0.76	0.38	0.35	0.87
Percent Change in the CPI	0.35	--	0.59	0.41	--	0.61	0.43	--	0.64	0.46	--	0.65
Percent Real Wage Change	-0.21	--	0.08	--	--	0.19	0.01	--	0.12	-0.08	--	0.22

PERCENT CHANGE IN REAL WAGE RATES
1978-1985, GENERAL DUTY NURSES

San Francisco	22%
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Los Angeles	12%
New York	8%

therefore, on the ability of New York to attract domestic nurses? Nothing in the Booz, Allen study refutes this assumption.

Taken together with similar and other flaws already noted, it is fair to say that the Booz, Allen assertion that there is no evidence of a direct wage effect due to the presence of these H-1 nurses in the New York City labor market is open to a great deal of question.

Entertainers

Almost without exception, entertainers are casual workers, that is, persons who work intermittently and usually for different employers. Contrary to popular impression, the pay of most entertainers is well below that of other professionals and many other American workers; they suffer extremely high rates of unemployment and underemployment. In the domestic entertainment industry at any given time there are many more American workers than there are jobs. Consequently, competition among entertainers for jobs is intense. A large number of American entertainers "make do" by working as non-entertainers in or outside the industry.

Despite this apparently large pool of unemployed or underemployed domestic talent, the report reveals that entertainers were by far the largest single group of nonimmigrant aliens admitted to the United States on H-1 visas in fiscal year 1986 and 1987. (On page 1 of Table A-1, see Musicians, Instrumental; Music Directors, Singers, Composers, Related Workers; Producers, Directors, Actors, and Other Entertainers; and Dancers & Choreographers). Referring to musicians who were the largest single occupational group admitted on H-1 visas in FY 1986, the report states, "We were not able to ascertain the

presence or absence of adverse impact on American workers in that year" (p. v).^{*} And then, in a manner which is repeated elsewhere in the report, an effort is made to avoid this admission by stating, "Nonetheless we concluded that any adverse impact on U.S. musicians and entertainers generally, is likely to be minimal..." (p. v). This statement is made without a trace of data or acceptable rationale to justify it.

One sentence ("Also, for H-1 entertainers, we were unable to obtain consistent data on wages" (p. v).) is apparently intended as the explanation for the complete absence in the report of wage data on entertainers. This is amazing! I assume that when determining whether or not an entertainer is of distinguished merit and ability, the salary paid would be given to the INS and therefore this information exists (or should exist). Again, the fact that such important data is missing in this report casts doubt on the conclusion that the employment of H-1 nonimmigrant aliens has had no adverse effect on the labor market for entertainers.

CONCLUSION

In summary --

- I agree with Booz, Allen that the H-1 program is not administered in conformity with statutory intent.
- Because of flawed data and methodology used in the Booz, Allen study and report, one can not conclude that there is generally no adverse impact on employment of U.S. workers as a result of H-1 admissions.

^{*} But contrast this with the statement: "The level of H-1 employment of musicians and composers in FY 1986 would therefore seem to have had some apparent labor market impact..." (p. III-23).

- To the contrary, there is some basis in the report for finding that nonimmigrant aliens admitted into the United States to work on H-1 visas do have an adverse impact on U.S. workers.

- Last year, Congress correctly perceived that the administration of the H-1 provision may be adversely affecting the governance of other nonimmigrant provisions as well as the domestic job market in certain fields and should be investigated. For this reason, it insisted on freezing proposed new regulations which merely continued present policies. This freeze should be continued until the reforms suggested by Booz, Allen and others can be evaluated and implemented.

Mr. MORRISON. Mr. Brown.

STATEMENT OF JEROME BROWN, PRESIDENT, NEW ENGLAND
DISTRICT 1199

Mr. BROWN. My name is Jerry Brown. I am the secretary/treasurer of the National Union of Hospital Health Care Employees, and the president of the New England district of that union, that represents 20,000 members in New England, many of whom are registered nurses and many of whom are also, the others are also health care workers.

And I am glad to be here.

I didn't want to wait this long.

I have a lot of reservations about this bill. They are much different than the ones Congressman Schumer was trying to make everyone feel comfortable with, don't worry about the certification process.

It is not going to be too onerous. Well, if it isn't, the bill isn't very good. I think that it is very important to address the question of training and retraining.

That is what I see is good about this. I echo some of the arguments about entity and so forth, here. People have been here, have been working.

The immigrant status is fine. I am in support of it.

But for the future for this program, I think not institution by institution, but region by region, State-by-State the industry has to show it is doing something to retain registered nurses. It can be done.

This is a difficult thing to do, but health care workers themselves, other health care workers themselves are the natural pool to this. There are other natural pools, but health care workers particularly are.

The whole question of forcing the industry to spend money on training its own work force and retraining its own work force, forcing the industry—that is public and private by the way, partnerships, however you want to call it, there are tax advantages, but I think it is real money that has to be spent to recruit students, get them in the school. And by the way, nontraditional students. That means people already in the work force.

They cost money because you have to give them something for their wages, something for stipend, something to get them. You have to change the system of nursing education. It is an archaic system, a horrible system. It is a system controlled by people who have an interest sometimes in making it difficult for people who go through it.

In many, many places you can't get into programs on a part-time basis. Part-time openings are very limited. Nontraditional students can't get into it. There are a lot of different things that have to be done.

I heard some of your comments earlier, this is a crazy place to be addressing the problems of the health care industry on this little part of it. But if this is the lever that starts the thing moving, then it is the right place to start.

It has to, in fact, happen. We are trying to do some of this stuff on a local basis. We are trying to do some of it in cooperation with the State of Connecticut. We find that many of these initiatives can work.

So we are in favor of the bill, but we think that the requirements for institutions to show that they are, in fact, working to recruit and retain the work force, those requirements have to be changed in this bill, if not in this bill it has to be done in order to alleviate the shortage in the long term. Everyone who is here says this is not the long-term solution to the problem.

The long-term solution is getting kids, but more than kids. Getting the people in the work force already who understand the hours, understand the work, understand the holiday work, who understand the problems. We have done surveys of membership throughout our union, and people want to get into the kinds of programs that will enable them to get into registered nursing. That is one of the sources that ought to be examined.

Thank you.

Mr. MORRISON. Mr. Appelbaum.

STATEMENT OF STUART APPELBAUM, COORDINATOR OF SPECIAL PROJECTS, RETAIL, WHOLESALE & DEPARTMENT STORE UNION, AFL-CIO, NEW YORK, NY

Mr. APPELBAUM. The RWD appreciates this opportunity to present, together with our local union, our views on H.R. 1507 and the critical issues addressed by the bill. We have prepared a more complete statement on H.R. 1507, which you have indicated will be included in the official record of these proceedings.

In the interest of time, I would simply like to touch upon several of the major points addressed in our full statement.

The RWDS membership includes not only nurses and other health care workers, but many other working people and their families who depend upon health care delivery systems.

In New York, where the RWDS and our local Union 99 represent many of the health care workers, the strains placed on the system have been especially acute. Cases of drug abuse, related violence, cut backs in health care and a variety of complex social problems have stretched the health care delivery system to the breaking point.

Combined with other tax factors, the result has been to drive many qualified, experienced personnel, especially nurses, out of the health care profession.

In desperation, hospitals in New York and elsewhere have turned to foreign nations in recruiting nursing personnel. These foreign nurses, especially those from the Philippines, served with distinction. In particular, they have performed many of the most difficult, thankless tasks in hospitals such as caring for terminally ill patients.

It is precisely because of the belief that the health care delivery system in New York could not survive without these professions that there has been help to secure their extensions for their visas. We have been successful in obtaining visa extensions for the Filipino nurses which carry them through the end of this year.

The need to seek such short-term extensions wastes time and resources, creates uncertainty and fear among the nurses and threatens the health care delivery system with consequences from the loss of a significant part of its work force. We, therefore, support those provisions of H.R. 1057 which would grant permanent resident status to certain aliens.

We support the establishment of a visa program which would be in effect for 5 years. We see those measures as a short-term solution to ensure an adequate supply of nurses are made available to our health care system.

Our union has tempered its support for visa extension with a caveat that foreign approval is not the long-term answer to the nursing shortage. We believe that H.R. 1507 addresses this concern, by providing a sound basis for reaching an eventual solution.

The bill was constructed to safeguard against abuses of the foreign improvement process by requiring hospitals to show cause why they go beyond the United States to fill vacancies, that they are taking timely and significant steps to recruit and retain American nurses, and by guaranteeing foreign nurses will not be used to undercut the wages and benefits of American workers.

We are also encouraged that the bill would require that a 3-year study be made by Government management and labor representatives to recommend permanent solutions to the nursing shortage. Taken together, these provisions can serve as a model in bringing foreign workers into the United States in a constructive and cooperative fashion.

Our union believes other steps must be taken to foster the retention of qualified nurses as a profession and build enrollments in nursing schools. We will continue to pursue such issues as increased compensation, better career ladders and improved child care as ways in which to achieve these objectives.

In the meantime the RWDSU supports the speedy adoption of H.R. 1507. We believe the bill is essential in order to avoid exacerbating the crisis in the health care delivery system.

We feel it is a necessary first step in reaching practical long-term solutions to our current nursing staffing shortages.

Again, thank you very much for this opportunity to appear before you today.

Mr. MORRISON. Thank you very much.

[The prepared statement of Mr. Appelbaum follows:]

Statement of

STUART APPELBAUM

COORDINATOR OF SPECIAL PROJECTS

RETAIL, WHOLESALE AND DEPARTMENT STORE UNION, AFL-CIO

On behalf of the members of the Retail, Wholesale and Department Store Union (RWDSU), I am pleased to present, in concert with RWDSU Local 1199, our views on H.R. 1507, a bill to amend the Immigration and Nationality Act to provide for special immigrant status for certain H-1 nonimmigrant nurses and to establish conditions for the admission, during a 5 year period, of nurses as temporary workers. We thank the Chairman for the opportunity to address this important issue.

The RWDSU strongly supports the passage of H.R. 1507. As the representative of nurses and other health care workers in New York City, we have seen first hand the critical problems facing New York's health care system. These problems would be exacerbated by the loss of qualified nurses from foreign countries who have filled a gaping hole in the system. We believe that H.R. 1507 represents a practical first step in solving some of the immediate health care problems facing New York and other cities.

Our union represents not only nurses and other health care workers in the New York area, but also many other workers and their families throughout the United States and Canada -- many of whom depend on the metropolitan area's health care delivery system. That system has been strained to the breaking point in recent years due to the complex and severe urban problems faced by New York, which are similar to those of other cities throughout the nation. The dramatic increase in the number of AIDS cases, the rise in drug abuse and the related increase in

/

violent crime, and the burden of treating the working and non-working poor who have no health insurance or inadequate coverage are but a few of the factors that have created a problem of crisis proportions for New York's health care delivery system.

Yet at a time when trained health care professionals are needed most, New York, like other areas in the nation, is facing a critical shortage of registered nurses. Years of low pay, the stress of working in crowded hospitals affected by cutbacks in funding, and the strain of coping with the AIDS and drug epidemics have driven many qualified nurses out of the profession and have resulted in declining enrollments in nursing schools.

As reported in the May 22, 1989 edition of the New York Times, "New York is experiencing one of the country's worst nursing shortages, with statewide registered nurse vacancies commonly estimated at 11 percent, and the nursing vacancies rates in New York City averaging nearly 15 percent." The Times goes on to cite a recent study which shows that New York City has an annual turnover rate for nurses of 23 percent, second only to Houston. New York Newsday recently reported that roughly one quarter of the funded nursing positions in New York's public hospitals are vacant.

When the nursing shortage began to manifest itself in the early to mid-1980's, hospitals turned to foreign countries as a source of qualified personnel. Nurses were recruited in several foreign nations, and the work force in New York City includes many from the Philippines. These RN's commonly perform valuable service in jobs where it has been particularly hard to recruit,

such as intensive care wards and caring for terminally ill patients.

The vast majority of the Filipino nurses who work in New York hospitals and health care facilities were admitted to the United States under H-1 visas which allowed them to work in this country for five years. After that time, they are required to return home for one year then reapply if they wish to re-enter the U.S. Many Filipino and other foreign nurses apply for "green cards," the official permit to work permanently in the U.S., but have found that their applications are either denied or delayed for long periods of time. We and our local, Local 1199 have heard reports that the waiting period of Filipino nurses to receive a green card is as long as 17 years.

In addition, under present circumstances the hospitals themselves cannot afford to lose a significant percentage of their nursing work force for any amount of time. If the nurses with expired H-1 visas stay on to assist in meeting the health care crisis in the United States, they risk deportation by the Immigration and Naturalization Service. If they leave, the consequences for hospitals in cities such as New York would be grave indeed.

Our union became involved last year in the effort to secure the extension of the H-1 visas of the Filipino nurses in New York City. Ironically, the fact that the visas were about to expire was brought to our attention by American-born nurses at Beth Israel hospital in New York who were deeply concerned over the further strain on the health care system and the remaining work

force that would have resulted from the loss of their friends and co-workers. We were pleased to work with Congressman Charles Schumer of New York and others in Congress to win first a temporary extension from the INS and then a full year's legislative extension of the H-1 visas of these nurses. Legislation passed late in 1988 assures that the affected nurses will be able to stay and work in New York until the end of 1989.

These extensions represented at best an emergency stopgap solution to the problem. It is both impractical and uneconomical for the Congress to revisit this issue every year and deal with the problem in a piecemeal manner.

We therefore support H.R. 1507 as the best possible solution to the problem at this time. The bill's greatest strength, in our view, is that it meets the short term problem of the nursing shortage while providing the mechanism to help reach a viable long term solution.

H.R. 1507 would grant permanent resident status to nonimmigrant aliens who entered the U.S. prior to January 1988 to perform services as registered nurses, who are currently employed as registered nurses, and whose visas are valid. It would establish a special pilot visa program which would be in effect for 5 years, and which would preempt recruitment of RNs under the H-1 visa program. Finally, it would provide for the appointment of an advisory group by the Secretary of Labor to study the effects of the legislation on the supply of RNs.

H.R. 1507 will not solve the nursing shortage in New York and other cities, but it will provide vital relief to the

beleaguered hospital systems in those areas by ensuring that a critical component of their nursing force will not be taken away during these difficult times. H.R. 1507 would also provide assurance to the dedicated nurses from the Philippines and other nations that they may continue to perform their professional duties without facing the difficult alternatives of either leaving their jobs at a critical time or staying and facing deportation.

Most importantly, H.R. 1507 is carefully constructed to foster the attainment of a long term solution to the nursing crisis. The bill has won the support of our union and of the Department for Professional Employees, AFL-CIO precisely because it recognizes that the use of foreign nurses is not in itself the best way to deal with the nursing shortage. Indeed, labor has traditionally been very wary of programs to import foreign workers because employers have used such programs to undercut the wages and benefits of American workers while using the threat of deportation to intimidate their foreign work force into accepting substandard pay and working conditions.

H.R. 1507 contains provisions to protect against abuses of the system. The bill mandates that hospitals and other health care facilities seeking to bring in foreign nurses must demonstrate a clear need for these workers, and that employment of the alien will not adversely affect the wages and working conditions of registered nurses similarly employed. Those foreign nurses who do come to work in American hospitals and facilities are to be paid at the same rates as their domestic

counterparts. Hospitals who utilize the services of foreign workers must also demonstrate that they are taking "timely and significant steps" to recruit and retain American nurses.

One of the most far-reaching provisions of H.R. 1507 is that section which mandates that a study of the bill's impact on the nursing shortage and progress on its solution be made by representatives of the U.S. Departments of Labor, Justice, and Health and Human Services along with hospital personnel and union officials. This group is to report its finding to Congress no later than January 1, 1992. We believe that the inclusion of such varied viewpoints on this body will lead to a careful examination of the issue and the development of practical steps to ease the crisis.

It is because of provisions such as these that organized labor, in this instance, has dropped its traditional wariness of immigration as a solution to American labor problems in this case. Our union and others are willing to work together with management to find ways in which foreign workers can be brought to the United States while protecting the rights of American and foreign workers and ensuring that the skills of these workers are used to meet a critical need in society and not to cause further problems. We are hopeful that the provisions of H.R. 1507 can serve as a model for programs to bring foreign workers into the United States in a constructive and cooperative fashion.

While we are happy to support efforts to protect the rights of the dedicated nurses from the Philippines and other foreign nations who are serving in American hospitals, our union has long

maintained that immigration alone is not an adequate solution to the nursing shortage in this country. We believe that several major steps must be taken to attract more dedicated, qualified personnel to the nursing profession and to retain those who currently serve in our hospitals.

Among the steps we support are: improved pay and benefits for nurses commensurate with their professional skills and dedication; the setting of specific career ladders for nurses so that more are attracted to make nursing a long term career; an increase in support staff to relieve nurses of many of their administrative and non-clinical duties and allowing them to focus on caring for patients; and improved child care policies to encourage qualified working mothers to remain in the nursing profession. Our union strongly supports these improvements as the surest way to attract and retain qualified nurses, and to recognize their significant contributions to our society.

Until a new generation of American nurses can be recruited and trained, however, we strongly support the solutions contained in H.R. 1507. The pressing problems facing our health care delivery system in New York and elsewhere and the very future of the nursing profession demand that this important first step be taken in meeting the shortage of qualified nurses. We urge Congress to act with all due speed in approving H.R. 1507.

Mr. MORRISON. Mr. Guthrie, the question I have for you, you are not really limited to your focus in the nursing situation, but generally express about H-1 concerns I share with you about it becoming an open-ended program to avoid confronting issues of the impact of bringing temporary workers and not so temporary when they are here 5 or 6 years over against developing a U.S. work force.

But I also am concerned about the micromanagement that arises in the labor certification process.

I heard Mr. Brown say something that to me is intriguing.

I would like your comments on it.

Can we develop more labor market regulatory tools to deal with the issue of competition between potential foreign workers and the development of the U.S. workforce instead of the huge certification process where we try to match a particular worker from somewhere with a particular institution and micromanage that?

What is your reaction to that possibility?

Mr. GUTHRIE. I would be reluctant to give you a categorical answer on that, Mr. Chairman. I would say that we would be most pleased to work with you and your staff in seeking ways to develop labor markets tests as opposed to case-by-case tests.

I have not seen anything yet that gives me much confidence that they will work.

Mr. MORRISON. Mr. Brown, I wonder if you would like to comment on that at all. Your suggestion was that the tools in the proposed H-4 program were inadequate to the task and that it was the industry as a whole or the marketplace as a whole that had to respond.

Mr. BROWN. If a hospital in Bedford-Stuyvesant is paying above the market rate, you ain't going to get near solving the crisis at Bedford-Stuyvesant. In other words, it can't be done hospital by hospital.

It can't be done in Mount Sinai in Hartford by itself. It has to be done in a labor market. There has to be a training program, a basis to bring huge numbers of people into the pool, not hospital by hospital. We get this—it just doesn't make sense.

There has to be a bigger way to do it.

The tests that were there that I read, you are presumed to have done it, your improvement basis, if you do some of these things, yes—I don't want to argue with Mr. Schumer. Somebody sends the Bush administration a letter saying you are doing these things and basically you are going to be certified. That is not going to get to it.

There has to be a Greater New York Hospital Association, whatever, industry associations and/or unions and/or combinations moving in with a specific program about training nurses. That is a lot different than each hospital saying we are paying 10 percent above the market rate, besides which we opened up 50 different slots in the nursing school this year but nobody applied for them.

Mr. MORRISON. Ms. Abelson.

Ms. ABELSON. I agree. In our training and upgrading fund of Local 1199, which has been working in concert with the Greater New York Hospital program there has developed a career nursing program which will allow for nurses aides and LPN's to upgrade and become registered nurses. It is a drop in the bucket.

It doesn't begin to meet the needs. I have said it before, but if we did all the correct things tomorrow, we are looking at an endemic shortage for at least another 10 years.

I agree wholeheartedly with Jerry. The natural pool of registered nurses for these hospitals is currently working in them. Generally there is a, they plan to stay in their institutions and have a commitment to return to that institutions as a registered nurse.

Mr. MORRISON. Thank you very much.

Mr. SMITH of Texas. Thank you, Mr. Chairman.

Ms. Abelson, in your testimony you mentioned that the industry, currently this money would be better spent on providing a general career ladder, salary advancement for staff RN's, and so forth.

Mr. Guthrie, you say, we believe this response is failing to solve the problem but has, in fact, exacerbated it.

In fact, all four of you all testified along the same lines. I guess my question for you all is one reason for your support of 1507, basically, as a way to cut your losses, which is to say let's let the foreigners who are here stay here, but through the labor certification, let's make it more difficult for additional foreigners to come into this country? Is that a fair statement?

Mr. Brown, let's start with you.

Mr. BROWN. That is totally wrong. We didn't sponsor the foreigners coming into this country. The employers did and the health care institutions did. Many of those people have made a commitment.

On the question of cutting losses, no. It is on the question really of training Americans to become nurses, which is in everybody's interest here.

Mr. SMITH of Texas. Let me go back to my question. If foreign nurses depress wages, why do you want more foreign nurses?

Mr. BROWN. I don't think anybody here says they want to have more foreign nurses. If you want to be just to those who are already here, we want to be just to those who have to come.

But we want to expand the pool of American nurses.

Ms. ABELSON. In our institutions foreign nurses do not depress wages. They are earning union rates. You talked to the wrong folks if you want to say foreign nurses depress wages.

They are not in our hospitals. Our hospitals pay union rates to nurses no matter where they emanate.

The problem, exacerbation of the nursing shortage and the depression of wages is a problem in nonunion hospitals.

The nursing shortage has impacted on my numbers in terms of total membership far more than the loss of the nurses here on H-1 visas would.

Mr. GUTHRIE. Mr. Chairman, we, I believe that if it were not for the foreign nurses, the wages would be even higher than they are today. What those foreign nurses are doing is distorting the labor market here.

Employers in traditional labor market should increase wages to attract American workers. What they have been doing instead is bringing in foreign workers.

Mr. SMITH of Texas. Let me continue my question, which is given the wage depression, given the fact that foreign nurses have that impact, why are all four of you all in favor of changing the law to

allow foreign nurses who are already here to stay who would otherwise be here only temporarily?

Mr. GUTHRIE. They are here. We feel they should be treated as many of their fellow workers have been allowed to adjust their status.

They are not going to distort the labor market any more than they already have.

Mr. SMITH of Texas. It is a humanness argument?

Mr. GUTHRIE. It is humanness, but they are not going to bring any more distortions into the labor market by keeping them here.

Mr. SMITH of Texas. The market has already been distorted. If it has been distorted, would you improve the market by having foreign nurses who are here who were supposed to leave after 5 years, go on back to their country of origin?

Mr. GUTHRIE. We think these foreign nurses who are here should be allowed to adjust their status. Humanness would prevail there.

Mr. APPELBAUM. I don't think we all agree that the presence of foreign nurses here distorts the wage structure, particularly in New York. I think it is more than just humanness, too.

As Cathy pointed out, the issues was first presented to us not by the foreign born nurses, but by the American nurses that were concerned about the impact on their work life if the foreign nurses were to leave.

They were concerned about the impact in terms of mandatory overtime and what was going to occur to them in performing their daily responsibilities.

I think we are also concerned that if the foreign nurses were to leave, other American nurses would leave the profession as well as they face changed responsibilities.

Mr. SMITH of Texas. Mr. Chairman, one more quick question.

You said you weren't concerned about the wage testimony. Yet on your testimony on page 5 you say you have been worried about it.

In your testimony you are concerned about it, about such programs that undercut the wages and benefits of American workers.

Mr. APPELBAUM. What I am concerned about is that if foreign nurses were to be brought in on a situation such as a strike or a walkout.

Mr. SMITH of Texas. I am not talking about that.

Thank you, Mr. Chairman.

Mr. MORRISON. Mr. Schumer.

Mr. SCHUMER. Thank you, Mr. Chairman.

Again I want to thank the witnesses for their testimony. And for all of those, the three who have worked on this legislation, I very much appreciate their concern and support of it.

I would like to address Mr. Brown because he has not been completely involved in this legislation.

I am interested in his comments. You know, when I look at the legislation, it seems to me that if I were representing nurses or representing my own viewpoint that the idea, number one, is that foreign nurses not be used to depress wages.

And the legislation, as I am sure my colleague from Texas realizes, prevents that from happening. That is pretty air tight. That is

one thing you can assure fairly easily that you don't have two classes of nurses.

Otherwise you are looking at a macropicture, which we want to avoid.

Second, the legislation requires that the industry, institutions or others specify what kind of long-term steps they are taking to recruit and retain U.S. workers. This committee can't do anything with money.

We can change the immigration laws any way we want, but we can't do anything with money. So, what you were talking about was the first point. That one, you know in other words, the individual measuring of each hospital and how great their need is, that is the place where the panel before you, the people on the other side of the table who have worked with us have the greatest number of problems.

Could you elaborate upon my understanding?

If points two and three were being taken care of, why is one, why does one—let's say, I mean I hope it will be administered to the letter of the law, but let's say it wasn't. Why does that trouble you so?

Mr. BROWN. I want to start, I am in favor of the bill. I think it is a step in the right direction.

Two, I know that these things come about somewhat by compromise. But the purpose, it seems to me, of the bill is to say, look, foreign nursing, nobody really wants it, but it is a necessary thing to do right now.

If we are going to do it, we want to build in certain incentives so that the problem goes away and we can take care of it domestically. I don't think the incentives that are in this bill have to be combined with Mr. Ackerman's bill, and so on, and so on, different ways.

But the incentives in this bill I don't think do it by asking an individual institution to—

Mr. SCHUMER. I missed your point.

Mr. BROWN. You are asking an individual institution to certify that it is doing something. It can't affect the—it by itself can't affect the real—

Mr. SCHUMER. One of the things we asked individual institutions to do is some of the things in Mr. Ackerman's proposal, and some institutions do do them. If this legislation basically says we are not going to eliminate foreign nurses, but there is sort of a weakening period, if you will, you know, I—

Mr. BROWN. I would like the incentive in the weakening to be a little bit stricter. That is the way I look at it. I saw what the incentives were.

It seems to me in our experience that it would, maybe you can't do it with the money, but somewhere—

Mr. SCHUMER. I thought you were addressing the first point rather than the third. The third, again, is a requirement as to what institutions we can do.

Let me ask all of the panel, any of the panel, just so we get it out on the record where the objections are coming from on the bill, and we are not getting any besides from the administration. I think there is something else coming out right now.

When you listen to some of the other panels, they say everyone knows there is a national shortage of nurses. We shouldn't have the legislation pinned on a hospital by hospital basis to prove there would be a disruption in the delivery of health care services.

Tell me why to your way of thinking and for the record so other people will see it that this is an important part of this legislation.

Mr. GUTHRIE. Let me take a shot at it. I think it is an important provision, Mr. Schumer, because it puts the obligations directly on the back of the employer. They are the entities hiring these foreign nurses. It is this collective approach that Mr. Brown is talking about I think might work out.

Until I saw that it would, I would prefer to have the employer establish that he really needs these people.

Mr. SCHUMER. Mr. Brown is really talking about a collective approach in terms of the training, recruiting, raising the wage scale and better working conditions of the nurses. That is a different point.

That is a different point, and I think I agree that that is the part of the bill we are going to have to be very vigilant about, otherwise we will be here again.

But on the disruption it is a little different. I mean let me be the devil's advocate for a moment, because I want to bring this out for the record.

Take New York. We all know there are nursing shortages just about for any hospital in New York. You are not going to find a hospital buried in one little corner of, say, Brooklyn or Queens or somewhere that isn't subject to these kinds of shortages because it is so severe and so dramatic. What would be wrong if the hospitals just certified that there were severe disruptions somewhere in New York, there is a desperate shortage of nurses, and a paragraph or two?

Mr. GUTHRIE. I suppose thinking in terms of worst cases that you might have a hospital which really didn't need those nurses but for competitive purpose thought they would be very nice to have on the payroll.

Mr. SCHUMER. That is what I wanted to bring out. That is a good point.

What do you say, Mr. Appelbaum?

Mr. APPELBAUM. I would add to that that even within the hospitals in New York there are disparities between the vacancy rates.

So there are some hospitals that may have a vacancy rate of perhaps 11 percent and other hospitals that have a vacancy rate of perhaps 25 percent.

Ms. ABELSON. My concern is less with the proof of disruption of service than it is with the demonstration that the industry is taking steps to solve the problem.

Mr. SCHUMER. I take it you and Mr. Brown—the whole panel agrees on that? Is that pretty accurate?

OK.

Thank you, Mr. Chairman.

Mr. MORRISON. I just want to comment, I find I continue to find it troublesome that labor representatives find themselves in the position of advocating this kind of itemized, private, individual sort of micromarket driven way of doing, solving this problem as opposed

to finding a governmental obligation in more defining of these labor markets.

It seems that we are relying on these hospitals to solve these individualized problems. The problem we are really trying to solve is whether or not it is a 15-percent vacancy rate or a 5-percent vacancy rate in a particular hospital as opposed to what are the labor market conditions in the city of New York, in the State of New York, in the State of Connecticut.

It seems to some rather old fashioned thinking about really solving this problem and on whom to put the obligation. It is very hard to make sensible immigration law on that basis because people rightly complain that you can spend years at a time proving a vacancy that never gets filled in order to satisfy these labor certification provisions and don't really seem to satisfy anybody's interest except perhaps just to keep people out indefinitely. But, in fact, the position is never filled by an American worker.

Ms. Abelson.

Ms. ABELSON. If I may, immigration policy that is proposed here as opposed to what? What exists today is the——

Mr. MORRISON. There is no policy at all.

Ms. ABELSON. Obviously. I expect that you will be seeing us in other committee rooms pushing, I should hope for a national health service. That may not be in the province of this committee, but it is in our agendas.

Mr. MORRISON. I understand that. My point is in dealing with these labor market questions we ought not to find ourselves driven back to the institution by institution, employer by employer analysis anymore than we would be in saying how we would define a health care delivery system that made sense because we get the same kind of problems when we itemize that way.

Warren Leiden, executive director of the American Immigration Lawyers Association, and Frank D. Bean, director, Population Studies Center, Urban Institute.

If you both would raise your right hand.

[Witnesses sworn.]

Mr. MORRISON. Somebody has to be on the last panel.

You have the broad overview of the theory of practice here. We are looking forward to you tying all the met in the meat package so we will know what to do at the end of this long day.

Mr. Leiden.

STATEMENT OF WARREN R. LEIDEN, EXECUTIVE DIRECTOR, AMERICAN IMMIGRATION LAWYERS ASSOCIATION

Mr. LEIDEN. I appreciate the opportunity to testify today. I have observed a number of other subcommittee hearings until now, and I appreciate the opportunity to get in early today.

In my opinion, we are really trying to address two problems in this hearing. One is the nursing shortage problem. That is a problem that is very complex.

Looking at the study of the Commission on Nursing and others, it is a very deep problem that is going to be faced in other occupations besides nursing, particularly occupations as Mr. Fish said earlier, occupations, traditional women's occupations of a generation

or two ago. But we observe and we strongly believe that this nursing shortage was not caused by foreign nurses.

I think there is an undercurrent of innuendo and supposition that somehow a small percentage of foreign nurses coming into the United States to supplement the work force has caused this, the nursing shortage.

We reject that. We think they are a symbol of the problem and we don't think they are the only solution to the nursing problem.

It is not a complete solution by any means. We agree with the Nursing Commission's conclusion that they will not significantly increase the number of nurses.

However, they do provide an important supplement to the U.S. work force and they help the situation from becoming even worse.

The other problem is the immigration problem. That is mainly characterized by the inadequate number of visas for employer sponsored immigrants. We have had the same number of visas for over 20 years.

Now with the internationalization of business and other factors, those visas are being used for a variety of businesses but their number has not increased. They are less available for nurses and other professionals and the wait is longer.

Experienced veteran nurses would be obligated to leave the United States before they can immigrate. Obviously, the simplest, cheapest solution to the immigration problem would be continuing to extend the nonpermanent stay of those nurses who are beneficiaries of a petition for immigration who received schedule A labor certification.

This would, obviously, keep the nursing shortage from getting worse and would solve the immigration shortage.

I think there are proposals before us today which go beyond the immigration problem and try to address the nursing shortage as well as the immigration problem. I want to thank Mr. Schumer for his initiative in this matter. He has been cooperative in discussing these matters with us.

We look forward to working with him in the future.

As far as the special immigrant status goes, we agree with the fact this would prevent the loss of many experienced nurses. On the—it is like the extension remedy in that it would provide permanent residence to these experienced nurses but would not include the per country limits.

We agree with those. We say most of these people would stay in the profession. We have in our written testimony pointed out several technical problems in the 1507 as drafted.

In particular, it requires the nurses have entered as H-1, nonimmigrants. Some nurses have entered as students. I don't think they should be precluded from qualifying.

Also, there is a language saying that the individual visa not have expired when they applied on the date of enactment. Of course, visas are something stamped on your passport allowing you to come into the country.

It is your nonimmigrant status that determines whether you are lawfully in the country or not lawfully in the country. We would recommend that that language be changed to the nonimmigrant status rather than if their visas have expired.

There should be a clarification that schedule A precertification would satisfy the statutory labor certification requirement and not in this one area where the shortage is so well recognized, require that individual itemized labor certification be required in other occupations where that shortage is not so clear.

We think the small number of licensed nurses remain a problem that must be addressed, whether it is in the special immigrant category or whatever. I am aware that in some parts of the country there are licensed out of status nurses grandfathered, still working.

Of course they are subject to exploitation, vulnerable to the lowest wages. In talking to my members around the country about it, they believe they were the only ones that had an adverse impact on U.S. workers, these out of status workers who are grandfathered, and have to stay with that employer and have no option.

As far as wage 4 category goes, we are very concerned and agree with concerns expressed. We have no doubt that the conditions can be satisfied in virtually every case.

It is a question of what is the cost of doing that, how much resources you divert from actually participating in recruitment and retention programs.

We would like to see—if this type of approach is adopted, we would like to see something that would allow more of a certification by House rules, more regional approach with samplings and surveys rather than requiring every hospital individually to satisfy these requirements on an annual basis.

It seems like it becomes a full time job then to keep certification.

We are particularly concerned at the transition point from when the final regulations are due until the beginning of the H-4 program. We think, we guess it would probably take 8 or 9 more months for the program to get going for all the hospitals waiting in line, for them to be approved and for them not to be able to sponsor, and nonimmigrant nurses during that period. We recommended a transition.

In addition to the simple extension of the H-1 program for the future immigrant, in addition to that simple program, we have also recommended in our testimony consideration for a more comprehensive program. That would be to think about something, what we have called a preimmigrant category, where there is a single adjudication for entry as a nonpermanent administration, as well as getting in line for permanent residence and labor certification, something based on a periodic certification, like nursing, which would permit the preimmigrant to enter the country in nonpermanent status but would put them in line for permanent residence. Of course, it would include labor certification.

We would suggest these preimmigrants be permitted to remain employed in the occupation, but not necessarily with a single employer, until they qualify for permanent residence or they become disqualified. We think this preimmigrant approach does provide some of the transition between what is now permanent residence and so-called temporary or nonimmigrant admissions on the other. This would bridge the gap for occupations where there is a recognized shortage and where people are really coming in on a temporary basis, in many cases knowing they will be subject to a petition for permanent residence.

I will stop now. Thank you.

Mr. MORRISON. Thank you.

[The prepared statement of Mr. Leiden follows:]

STATEMENT OF
WARREN R. LEIDEN, EXECUTIVE DIRECTOR
AMERICAN IMMIGRATION LAWYERS ASSOCIATION

Mr. Chairman and distinguished members of the Committee:

I am pleased to have the opportunity to testify on behalf of the American Immigration Lawyers Association regarding proposals that address the shortage of professional nurses in the United States and the foreign born nurses that supplement the U.S. nursing profession.

INTRODUCTION

AILA members represent a wide range of employers that have petitioned for the admission of foreign professional nurses as both nonimmigrants and immigrants. These employers range from large hospitals, hospital corporations and associations, down to the relatively small facilities including nursing homes and other treatment centers. Our members represent such employers in all parts of the country and represent foreign nurses from all parts of the world.

Although we do not presume to claim expertise in the field of labor market economics or general labor policy, we are quite familiar with the practical, day-to-day experiences and options of a large number of health and hospital facilities of all types. Moreover, our expertise does lie in understanding the practical impact and consequences of immigration law procedures and requirements, such as suggested in the proposals under consideration by this Committee.

For some time, the United States has experienced a pervasive nationwide shortage of professional nurses. According to the Department of Health and Human Resources Commission on Nursing, the shortage numbers around 137,000 nurses nationally. The national job vacancy rate for nursing positions in hospitals is over 10 percent nationally, and the vacancy rate in certain inner-city public hospitals ranges from 15 to 20 percent. The causes of this shortage include both "demand-side" and "supply-side" factors of a varied and complex nature over which there is some disagreement.

As a result of this shortage, employers in the hospital and health care field have been obliged to supplement the U.S. workforce with qualified professional nurses from abroad. However, recent restrictions imposed by the Immigration and Naturalization Service, coupled with the limited allocation of employee-sponsored immigrant visas, has required congressional action to prevent the departure of thousands of experienced foreign nurses working at U.S. facilities who are not yet eligible for immigrant status due to quota backlogs. Despite increased efforts to recruit and retain U.S. professional nurses, including salary increases ranging from 16 to 24 percent in New York City and a national average increase of over 10 percent, impatience and frustration over problems in the nursing profession have resulted in a backlash against foreign professional nurses. This backlash finds voice in calls for increased restrictions and requirements on health and hospital employers that seek to supplement the U.S. workforce with foreign born nurses.

The two bills under consideration today represent two approaches to the U.S. nursing shortage and the employment of foreign born nurses. H.R. 1507, the Immigration Nursing Relief Act of 1989, addresses the nursing shortage by granting permanent residence to those foreign nurses in lawful nonimmigrant status, while establishing a five-

year period during which employers seeking to sponsor nonimmigrant foreign nurses would be obliged to meet a new set of requirements and restrictions intended to encourage the recruitment and retention of U.S. workers.

The Emergency Nurse Shortage Relief Act of 1989, H.R. 2111, establishes a number of programs to increase the supply of U.S. professional nurses and provide educational assistance to bring more U.S. workers into the nursing profession. While these recruitment, retention, and educational programs are taking effect, H.R. 2111 provides a one-year extension for nonimmigrant foreign nurses who are near the end of their lawful stay that may permit their acquiring immigrant status without having to depart from the United States.

Both sponsors have offered their proposals to encourage discussion, debate, and compromise. They have welcomed comments, suggestions, and recommendations, and I hope that our statement today will be taken in this spirit.

This statement will begin with some background information and observations, proceeds to an analysis of the two bills under consideration, followed by our recommendations and an alternative proposal for consideration by the sponsors and this Committee.

Two principles that have guided our thinking on this subject.

First, the employment of foreign professional nurses is not the cause of the current nursing shortage, but is rather a symptom of this complex problem. Unfortunately, the temptation to blame the current nursing shortage on foreign born professional nurses has been too great for some to resist. It is a regrettable aspect of our nation's history that, in dealing with a variety of social and political issues, immigrants and the foreign born have sometimes been the symbolic scapegoat of much deeper problems.

Any reasonable assessment of the facts must concede that the admission of foreign professional nurses, only recently approaching 5,000 or 6,000 per year, could not possibly have caused the shortage of at least 130,000 professional nurses in an occupation shared by over 2,000,000 Americans. Conversely, preventing or unduly restricting the employment of foreign nurses cannot be expected to relieve the U.S. nursing shortage, but must surely make it worse.

Second, responsible relief for the U.S. nursing shortage must primarily focus on the encouragement of recruitment, retention, and education to increase the number of qualified U.S. nurses working in the profession.

Although outside our area of expertise, it is plain to us that there must be a joint effort between the private and public sector, and between management and labor, to increase the number of U.S. professional nurses working in health care facilities. Recent estimates indicate that, of the 2,000,000 registered nurses in the U.S., only 80 percent are now employed as professional nurses (1,600,000). The Health and Human Services Department's Commission has made a series of recommendations that should contribute significantly to the alleviation of the present shortage.

BACKGROUND TO NURSE SHORTAGE RELIEF ACTS

The following sections provide some background and factual information that lay the foundation for the current nursing relief proposals.

THE SHORTAGE OF PROFESSIONAL NURSES

The Department of Health and Human Services Secretary's Commission on Nursing has prepared definitive and comprehensive reports on the nature and extent of the shortage of professional nurses. The reports have found that the shortage of registered nurses is "real, wide-spread, and of significant magnitude." Nursing shortages at hospitals, which employ two-thirds of all registered nurses, is particularly acute. While hospitals of all sizes in both rural and urban areas have been hard-hit by the current nurse shortage, the larger hospitals, and hospitals in large urban areas, face the most serious problems.

The current nurse shortage is further exacerbating the chronic shortage of registered nurses in nursing homes. Thirty-four percent of nursing homes have reported "severe" registered nurse shortages.

The Commission found that the current nursing shortage is primarily the result of an increase in demand as opposed to a reduction in the number of available nurses. Hospital demand for professional nurses is increasing; the number of nurses employed per patient has increased as the average severity of hospital patient illness has also increased due to a number of factors.

The number of licensed professional nurses is at an all-time high (estimated 2,000,000), and, of these, a record 1.6 are employed in nursing. However, there have been continuing declines in admissions, enrollments, and graduations from nursing programs. Moreover, until 1988, the supply of nurses was suppressed by chronic problems associated with the nursing profession including low average salaries and compressed salary ranges, working conditions, and a poor professional image.

In 1988, the average maximum salary for registered nurses increased by 10.6 percent, to \$32,160 annually. In New York City, the nurses in city hospitals received a 24 percent increase in their maximum salary last year, to \$33,896, and a 16 percent increase in starting salaries, to \$29,267.

Despite these measures to recruit and retain nurses, *the Commission concluded that the future supply of registered nurses will not be adequate to meet anticipated demand.* And, although the Commission found that foreign nurses cannot be relied on as a source for *significantly increasing* the overall domestic supply of RNs, it is clear that foreign nurses, to the degree they are currently employed, prevent the nursing shortage from being worse than it already is.

FOREIGN NURSES AS PERMANENT IMMIGRANTS

With appropriate licensure in the U.S., foreign nurses can qualify as employer-sponsored immigrants under the 3rd preference as members of the professions and under the 6th preference as skilled workers. As for all 3rd and 6th preference immigrants, labor certification is required to show that sufficient, qualified U.S. workers are not available and that the wages and conditions of employment will not adversely affect other U.S. workers. Due to the wide-spread and pervasive shortage of nurses, individual case processing of labor certification is not necessary. Professional nurses are one of the occupations found on the Labor Department's Schedule A of Recognized Shortage Occupations, for which the scope of scrutiny focuses on a bona fide job offer, payment of the prevailing wage, and acceptable working conditions.

Although Schedule A labor certification substantially reduces the processing time for employer-sponsored immigration of professional nurses, the low number of visas available annually for employer-sponsored immigrants, and certain "per country" limitations have contributed to significantly delaying the arrival of qualified foreign nurses as permanent residents.

Under existing law that has remained unchanged for years, only 54,000 visas are made available in total for 3rd and 6th preference immigrants. Because this number includes such immigrants' dependents, the actual number of principle worker-immigrants rarely exceeds 23,000 per year. This is the total number available for all types of occupations, managers, executives, engineers, technicians, analysts, and other professionals and skilled workers. As a result, the annual number of immigrant slots open to foreign nurses is limited. Although the Immigration and Naturalization Service does not collect data by occupation, we estimate that at most only several thousand immigrant visas are available to professional nurses annually under current law. Obviously, increases in the allocation of employer-sponsored visas, now the subject of legal immigration reform, would greatly change this situation.

Further complicating the limitations on the immigration of foreign nurses are the so-called "per country" restrictions. Under current law, immigrants who are nationals of a single country cannot exceed 20,000 per year. Filipinos, who make up the largest source of qualified foreign nurses, use over 15,000 of the per country visas for family immigration. In 1987, the per country limitation resulted in about 1,500 principle 3rd and 6th preference immigrants from the Philippines.

The result of these limitations are substantial backlogs for Filipino immigrants in both the 3rd and 6th preference. In fact, 3rd preference for the Philippines is hopelessly over-subscribed. Current immigrants under the 3rd preference from the Philippines would have to have been petitioned for in the early 1970s! Some 17,800 Filipinos were registered 3rd preference immigrant visas applicants at U.S. consular offices as of January, 1989. Under the 6th preference category, Filipino nurses must wait over 4 years from the date of filing to receive immigrant status.

Although Filipino nurses represent the worst case, the combination of the time required for processing and the backlogs due to quotas translate into delay for the immigration of foreign nurses. Generally speaking, an immigration attorney would advise an employer that almost 2 years are needed in order for a professional foreign worker to obtain permanent residence as a 3rd preference immigrant.

H-1 NONIMMIGRANT CLASSIFICATION FOR FOREIGN NURSES

As a result of these delays and backlogs, employers frequently sponsor foreign professional nurses as H-1 nonimmigrants. The H-1 nonimmigrant category has, for almost 20 years, included professionals, prominent or preeminent individuals as persons of distinguished merit and ability. H-1 nonimmigrants may initially be admitted for 3 years, but their lawful stay may be extended for additional periods to a maximum of five years. A sixth year may be granted under extraordinary circumstances.

An added advantage of the H-1 nonimmigrant category for foreign nurses is that the paperwork and technical processing can be accomplished in a relatively short period of time, sometimes less than 2 months. According to the recent INS study, some 6,000 H-1 nurses were admitted in fiscal year 1987, some 5,800 in fiscal year 1986.

Prior to 1987, the backlog and delay in obtaining permanent residence as a 3rd or 6th preference immigrant was less problematic due to the ability to extend H-1 nonimmigrant status. Foreign professional nurses from over-subscribed countries such as the Philippines could remain in sponsored H-1 nonimmigrant status for as many years as were necessary to reach the quota for 3rd or 6th preference visas.

This condition changed in February, 1987, when the Immigration Service promulgated final regulations limiting the maximum stay of an H-1 nonimmigrant to 5 years, or 6 years in "extraordinary circumstances." Initially, in applying this regulation, the Immigration Service held that the nationwide shortage of professional nurses was not an extraordinary circumstance that justified a 6-year H-1 nonimmigrant stay.

The new 5-year limit had immediate repercussions in the health care industry where thousands of foreign professional nurses faced the prospect of having to depart the United States prior to reaching their eligibility date for permanent residence, thus depriving U.S. health care facilities of staff with 5 or more years of experience and the prospect of further impaired patient care. In June, 1988, the immigration service reversed its earlier policy and agreed that the U.S. nursing shortage was indeed an extraordinary circumstance that warranted the blanket extension of fifth year H-1 nonimmigrant nurses' stay for one more year. At the same time, however, the INS made it clear that they would provide no further administrative relief, and that Congress would have to act to provide further extensions of H-1 nonimmigrant nurses' stay beyond 5 or 6 years.

THE IMMIGRATION AMENDMENTS OF 1988

After preliminary consideration of a bill introduced by Congressman Schumer (almost identical to the Immigration Nursing Relief Act of 1989, H.R. 1507, now under consideration) Congress acted to extend the lawful stay of H-1 nonimmigrant nurses through December 31, 1989. This extension was available to those nurses whose stay would otherwise expire in 1988 or 1989 or whose nonimmigrant status did expire during 1987 but who filed an appeal of the denial of extension of such status.

The bills now under consideration could provide further relief to those nonimmigrant nurses whose status was extended to December 31, 1989 who may number up to 10,000 professionals in the United States. In addition, the proposed legislation would address the circumstances faced by health care facilities and foreign nonimmigrant nurses who will reach the fifth year of their lawful nonimmigrant stay prior to qualifying for permanent residence as an immigrant.

THE EMERGENCY NURSE SHORTAGE RELIEF ACT OF 1989, H.R. 2111

Sponsored by Congressman Ackerman and others, H.R. 2111 addresses the nursing shortage largely through providing grants for programs to increase the number of U.S. professional nurses.

The nurse recruitment program permits the Secretary of Health and Human Services to make grants to public and nonprofit private entities for programs that promote nursing as a career choice, educate the public regarding the value of the nursing profession, identify public secondary school students with an interest in health care and provide them with internships, and to recruit nursing students not traditionally well represented in the nursing profession.

The inactive nurse reactivation and training programs authorize the Secretary of Health and Human Services to make grants to public and private nonprofit entities and schools of nursing for programs to encourage and assist trained nurses to reenter the profession, to train or educate reentering nurses as nurse practitioners, midwives, or in other specialized nursing skills, and to provide tuition assistance to students enrolled in educational programs that facilitate their reentry into the nursing profession.

The practicing nurse retention program authorizes the Secretary of Health and Human Services to make grants to health care facilities for programs that increase the attractiveness of the nursing profession as a career choice through changes in traditional wage structures, flexibility of employment options and benefits, and restructuring the role of nurses in health care facilities, and that provide for advancement in the nursing profession to encourage nurses to continue education in nursing. The loans for continued nurse training program authorizes the Secretary of Health and Human Services to establish a program to provide educational loans for registered nurses seeking further education as nurse practitioners, midwives, or in other needed specialized nursing skills.

H.R. 2111 also authorizes an income tax credit for corporations that provide "qualified nursing scholarships" to individuals who are candidates for a degree as a registered nurse or for higher nursing degrees.

H.R. 2111 also requires the Secretary of Health and Human Services to designate geographic areas that have a severe shortage in the number of nurses necessary to adequately serve the health needs of the area as "*nursing crisis areas*." The Secretary is also directed to designate areas of needed specialized nursing skills or fields of nursing skill or expertise in which there are a shortage of practicing nurses necessary to adequately serve the health needs of persons that require such skills or expertise. The designations of *nursing crisis areas* and areas needing specialized nursing skills are to be reviewed at least annually for discontinuation or redesignation.

Finally, H.R. 2111 directs the Attorney General to provide to H-1 nonimmigrant nurses in *nursing crisis areas* (upon completion of 5 years) an extension of such status for at least an additional year. This extension of status may not be granted unless the Secretary of Labor certifies that the continuing employment of the alien will not adversely affect the wages and working conditions of registered nurses in the United States.

THE IMMIGRATION NURSING RELIEF ACT OF 1989, H.R. 1507

H.R. 1507, sponsored by Congressman Schumer and others, addresses solely the issue of foreign nonimmigrant nurses in the United States through two main provisions. The first provides immediate relief for foreign professional nurses already in the United States; the second imposes new restrictions on the sponsorship of nonimmigrant foreign nurses by health care employers.

SPECIAL IMMIGRANT STATUS FOR H-1 NONIMMIGRANT NURSES

H.R. 1507 extends *special immigrant* recognition to individuals 1) who entered the United States before January 1, 1988 as an H-1 nonimmigrant registered nurse, 2) whose visa as such a nonimmigrant had not expired as of the date of enactment (including those whose status was extended by the Immigration Amendments of 1988) and who is employed as a registered nurse on the date of enactment, and 3) who has received approved labor certification [INA §212(a)(14)] before the grant of special immigrant status.

Special immigrant status would confer almost immediate permanent residence on those H-1 nonimmigrant nurses who qualify and would include their spouses and minor children. Special immigrants are not subject to any per country limitations and there is no limit on the number of special immigrants who may be admitted or adjusted annually. AILA's comments and suggestions with regard to this proposal are set forth later in this statement.

NEW RESTRICTIONS ON NONIMMIGRANT NURSES

H.R. 1507 also provides that, for the 5-year period beginning the first day of the ninth month after the date of enactment, health care facilities would no longer be permitted to sponsor foreign professional nurses to perform services as registered nurses under the H-1 nonimmigrant category. Instead, H.R. 1507 establishes a new, H-4 category for individuals coming temporarily to the United States to perform services as a registered nurse.

In order to qualify for H-4 nonimmigrant status, the alien must meet certain professional qualifications now required by regulation [8 CFR §214.2(h)(2)(vi)]. Generally, these require that the individual:

- a. has obtained a full and unrestricted license to practice professional nursing in the country where he or she obtained nursing education or received nursing education in the United States or Canada;
- b. has passed an appropriate examination (approved by the Secretary of Health and Human Services) or is licensed under state law to practice professional nursing in the state of intended employment; and
- c. is fully qualified and eligible under the laws of the place of intended employment to practice professional nursing as a registered nurse immediately upon admission to the United States and is authorized under such laws to be employed by the facility. This latter qualification would not apply to the extent that state or local laws limited the services a foreign nurse may provide if the individual is not employed to provide services in violation of such law.

H.R. 1507 also adds requirements not in existing law. A petition to sponsor an H-4 nonimmigrant nurse would not be approvable until the Secretary of Labor determines and certifies to the Attorney General that certain conditions have been met with respect to the facility for which the individual will perform nursing services. The conditions that must be certified by the Secretary of Labor with respect to the health care facility seeking to sponsor and employ the nonimmigrant nurse are that:

- a. there would be a substantial disruption through no fault of the facility and the delivery of health care services of the facility without the services of such an alien;
- b. the employment of the alien will not adversely affect the wages and working conditions of registered nurses similarly employed and the alien will be paid at the prevailing wage rate for registered nurses similarly employed by the facility (current law applicable to H-1 nurses does require that the alien be paid commensurate with the qualifications of the position, although not using the "prevailing wage" concept);

- c. the facility has demonstrated that it has taken and is taking timely and significant steps designed to recruit and retain sufficient registered nurses who are U.S. citizens or immigrants authorized to perform nursing services (in order to remove as quickly as reasonably possible the dependence of the facility on nonimmigrant registered nurses);
- d. there is no strike or lockout in the course of a labor dispute that precludes approval and the facility certifies that the employment of such alien is not intended or designed to influence an election for a bargaining representative for registered nurses at the facility; and
- e. notice of the filing of the H-4 petition has been provided to the bargaining representative of the registered nurses at the facility or if there is no such bargaining representative, notice is provided through posting in conspicuous locations.

SUBSTANTIAL DISRUPTION REQUIREMENT

H.R. 1507 further provides that the requirement that there would be a substantial disruption without the services of the H-4 nonimmigrant nurse can be met by a facility if it is located in an urban area which the Secretary of Labor determines has a significant shortage of registered nurses. However, the substantial disruption requirement cannot be met by any individual facility during the one-year period following the layoff of any registered nurses.

REQUIREMENT OF SIGNIFICANT STEPS DESIGNED TO RECRUIT AND RETAIN REGISTERED NURSES

H.R. 1507 provides some guidance as to timely and significant steps designed to recruit and retain sufficient registered nurses who are U.S. citizens or immigrants. Each of the following is designated as a significant step reasonably designed to recruit and retain registered nurses:

- a. operating a training program for registered nurses at the facility or providing an opportunity for training elsewhere;
- b. paying registered nurses at wages above the prevailing wage rate for registered nurses in the geographical area;
- c. providing adequate support services to free registered nurses from administrative or other non-nursing duties; and
- d. providing reasonable opportunities for meaningful salary advancement by registered nurses.

H.R. 1507 further provides that this list shall not be considered an exclusive list of significant steps that may be taken to meet the mandated requirement.

DURATION OF CERTIFICATION OF FACILITY REQUIREMENTS

H.R. 1507 also provides that the Secretary of Labor certify that a health care facility meets the conditions other than the "substantial disruption" requirement, shall be valid for a period of one year. During the one-year period, the Secretary of Labor's findings continue to apply to H-4 nonimmigrant nurse petitions if the facility certifies that it continues to comply with such conditions.

However, the certification of compliance with the conditions may be revoked by the Secretary of Labor upon a finding that the facility no longer meets the conditions or that there was a misrepresentation of material fact in the application for certification.

After certification by the Secretary of Health and Human Resources that the "substantial disruption condition" is met and certification by the Secretary of Labor that the conditions relating to adverse affect, prevailing wage, steps to recruit and retain, no labor dispute, and notice, have been met, the facility may file H-4 nonimmigrant petitions for one or more foreign registered nurses.

Such H-4 nonimmigrants may be admitted for an initial period of up to 3 years with extensions. However, the total period of admission is not to exceed 5 years or 6 years in the case of extraordinary circumstances, as determined by the Attorney General.

DURATION OF THE H-4 NONIMMIGRANT NURSE PROGRAM

H.R. 1507 provides that the H-4 nonimmigrant nurse program expires at the end of the 5-year period that begins on the first day of the ninth month after the date of enactment.

ANALYSIS AND COMMENTS ON H.R. 1507

The two main proposals of H.R. 1507 are significantly controversial, although perhaps from different quarters and for different reasons.

ELIGIBILITY FOR SPECIAL IMMIGRANT STATUS

H.R. 1507 permits certain H-1 nonimmigrant nurses to qualify for permanent residence as special immigrants. We believe that the sponsors intend that all foreign professional nurses in lawful nonimmigrant status on January 1, 1988 should qualify for this status. However, there are certain problems in the proposed language which will prevent this goal from being fulfilled.

First, the special immigrant classification is limited to those who "*entered* the United States before January 1, 1988 as a nonimmigrant under paragraph (15)(H)(i) [of the INS]." This formulation would exclude all lawful H-1 nonimmigrants who entered under a different nonimmigrant classification such as F-1 student who thereafter lawfully changed their nonimmigrant classification to H-1.

We assume this was an oversight in drafting, and we recommend the language be changed to indicate that eligibility would extend to those who were present in the United States on January 1, 1988, *in* lawful nonimmigrant status under paragraph (15)(H)(i)....

Second, we strongly recommend that the cutoff date be changed from January 1, 1988 to January 1, 1989 so as to maximize the number of nurses that could be relied on by health care facilities without having to worry about whether their immigrant visa number will be reached before reaching the 5-year limitation. This would ensure that the legislation has the most substantial impact on the current nurse shortage.

Third, the special immigrant status is limited to those H-1 nonimmigrant nurses "whose *visa* as such a nonimmigrant had not expired as of the date of enactment...." By requiring that the nonimmigrant visa not have expired, instead of the nurse's lawful nonimmigrant *status*, this provision would eliminate a large portion of those who would otherwise qualify for the special immigrant status. This is because many H-1 nonimmigrant nurses are initially admitted with a visa stamp in their passport that later may have expired. Once they are in the United States, their lawful H-1 nonimmigrant stay can be extended by the Immigration Service for up to 5 or 6 years regardless of the expiration of the nonimmigrant visa. This often misunderstood distinction between the visa and the lawful nonimmigrant status may have caused this confusion. We believe it was an inadvertent error. We recommend this provision be amended to make the sponsors' intent clear that special immigrant status would be available to foreign professional nurses "whose status as such a nonimmigrant had not expired as of the date of enactment of this subparagraph...."

The final requirement for special immigrant status is a certification under §212(a)(14) "before the date the immigrant is granted special immigrant status under this subparagraph." This refers to permanent labor certification -- the certification of the Secretary of Labor that there are not sufficient qualified U.S. workers available at the time and place of employment and that the alien's conditions of employment will not adversely affect the wages and working conditions of U.S. workers. It is not clear from the statutory proposal whether H.R. 1507 intends that an individual labor certification be performed for each such special immigrant applicant in addition to the blanket labor certification now available under Schedule A [20 CFR §656.10(a)] of the Department of Labor. We believe clarification is desirable. Individual labor certification seems to make little sense in an occupation where the pervasive labor shortage is so widely recognized that the Secretary of Labor has designated it as one of only two "pre-certified" shortage occupations in the U.S. for permanent labor certification purposes. In addition to the considerable expense involved in individual labor certification, a substantial time delay must be expected as part of the routine price of individual labor certification. The imposition of the individual labor certification procedure, if intended by the sponsors, seems redundant and unnecessary. It would only add to the expense of providing healthcare as well as further aggravating the nursing shortage crisis.

Therefore, AILA recommends that the requirement of labor certification for special immigrant status either be eliminated in its entirety or that it be made clear that

the labor certification required is satisfied by the Schedule A precertification now part of the Department of Labor regulations.

Finally, we are concerned that, even if enacted, many H-1 nonimmigrant nurses might be unable to qualify for and complete the paperwork for special immigrant status before the expiration of their current H-1 nonimmigrant stay. No provision is made in the law for H-1 nonimmigrant nurses whose final extension will expire on December 31, 1989, the final date provided by the Immigration Amendments of 1988 for extension of H-1 nurses in the U.S. whose fifth or sixth years expired in 1987 or 1988 but who would have difficulty completing and receiving work authorization and the right to remain in the United States in time to prevent their enforced departure from the U.S. Therefore, if the special immigrant status is enacted, some extension or relief must be provided to those lawful H-1 nonimmigrants for the duration of the period during which it takes to apply, qualify, and receive permanent resident benefits under this provision. Failure to do this will require departure of such applicants until this process is complete, which would further aggravate the nursing shortage in the U.S.

We are also concerned about those foreign professional nurses who are not or will not be in lawful nonimmigrant status on the cutoff date or on the date of enactment. This includes professional registered nurses who lost H-1 nonimmigrant status due to loss of their nursing job for any of a variety of job-related reasons. Although H-1 nonimmigrants can lawfully change from one employer to another, reinstatement to lawful H-1 nonimmigrant status, even although the interruption in employment may have been only for a day, is exceedingly rare. This class also includes those nurses whose 5th or 6th year H-1 stay expired in 1987 or 1988 but who did not qualify for the extension to December 31, 1989, because they did not file an appeal of the denial of their extension request prior to the date of enactment of the Immigration Amendments of 1988 or because they were unaware of the law.

It is difficult to remember that in 1987 and part of 1988, the Immigration Service was as definite and rigid in denying extension to H-1 nonimmigrant nurses beyond the 5th year as the agency now is in denying extension beyond the 6th year. Only certain employers and H-1 nonimmigrant nurses were willing to file appeals of extension denials when that cause seemed entirely futile to most immigration law professionals. Although the Immigration Amendments of 1988 permitted filing the required appeal up until the date of enactment, the short period from its approval by the House Judiciary Committee to its endorsement by the President's signature left many employed registered nurses in the cold.

Ironically, these now out-of-status nurses, for whatever reason lawful status was lost, are the greatest anomaly in the national nursing shortage. In most cases, such foreign registered nurses were formerly lawful H-1 nonimmigrants, most are so-called "grandfathered" employees such that their employers cannot be penalized under the employer sanctions provisions of the Immigration Reform and Control Act of 1986. Because such nurses are no longer in status and must continue with the same employer in order to avoid the effect of employer sanctions, they are the most vulnerable, most exploitable, and least well-paid group of nurses in the United States. Although their

number is small in comparison to the 1.6 million employed registered nurses in the United States, their hardship is very real, their experience and value to the United States is great, and, if any foreign nurses have an adverse affect on wages and working conditions of other U.S. nurses, it must be this class. Rather than continuing the backlash against foreign nurses, we recommend that this class be permitted some avenue of reinstatement to lawful nonimmigrant status or the special immigrant category proposed in H.R. 1507.

Finally, we have some concerns over the political viability of the special immigrant proposal of H.R. 1507. In the past, the extension of special immigrant status to H-1 nonimmigrant nurses has been characterized as a new "legalization" or "amnesty" program. Because special immigrant status is conferred on lawful H-1 nonimmigrant nurses who may have been in the U.S. as little as 2 years, accusations of unfair treatment and "line jumping" in comparison to other employer-sponsored immigrants is possible.

If the political viability of extending special immigrant status to such nonimmigrant nurses becomes problematic, we recommend the sponsors consider providing some interim or pre-immigrant status to extend such nurses lawful stay beyond the 5- or 6-year limit imposed by the Immigration Service until their preference category and per country quotas are met, thus providing lawful permanent residence in conformity with current law applicable to all other nonimmigrants and immigrants.

ANALYSIS AND COMMENTS ON THE NEW H-4 NONIMMIGRANT CATEGORY FOR PROFESSIONAL NURSES

Before addressing AILA's specific concerns and suggestions regarding the proposed new H-4 nonimmigrant status for professional nurses, several observations of a general nature are appropriate.

On first consideration, it seems anomalous that, in the face of a pervasive nationwide shortage of 137,000 professional nurses and rapidly escalating health care expenses, Congress would now decide to impose new restrictions and burdens on health care facilities who seek to supplement the insufficient U.S. workforce by sponsoring the admission of some 6,000 nonimmigrant nurses annually.

Most health care facilities, particularly those of substantial size and organization, should have confidence in their ability to satisfy the qualifications and conditions imposed by the new H-4 nonimmigrant nurse category. Based on the immigration bar's collective experience, however, satisfaction of these restrictions will come at a price that is not now extracted. In order to meet the conditions and restrictions imposed by H.R. 1507, health care facilities can expect to experience a number of new difficulties.

1. Substantial paperwork and administrative burdens.

H-4 nonimmigrant sponsors would be obliged to obtain evidence of the Secretary of Labor's determination that the intended work place is in an area which has a significant shortage of registered nurses or must prove that on an individual basis that there would be a substantial disruption in the delivery of health care services without the services of

the nonimmigrant nurse. Each nonimmigrant sponsor must also apply for and persuade the Secretary of Labor to make a determination with regard to their facility that a) the employment of the alien will not adversely affect the wages and working conditions of registered nurses similarly employed, b) the alien will be paid at the prevailing wage rate for registered nurses similarly employed at the facility, c) that the facility has taken and is taking timely and significant steps to recruit and retain U.S. registered nurses, and d) that notice of the petition for H-4 nurses has been provided to the bargaining representative or has been posted at the facility.

There is no evidence or opinion in the record as to what the Secretary of Labor would require of facility-sponsors to meet their burdens of proof and persuasion in obtaining such certifications. Judging by the current requirements of the Labor Department of permanent labor certification in individual cases, it is difficult not to assume that the paperwork and administrative requirements of obtaining such certifications will be substantial. Under the permanent labor certification process, which requires similar findings of the employer-sponsor, applications for labor certification usually require the completion of up to 20 pages of forms, certifications, copies of evidence, and other required documents. As proposed, the Secretary of Labor is given 8 months to designate, by regulations, the process by which the new H-4 certifications will be handled -- what will be required of the health care facilities, what actions will be taken by Labor Department officers, what standards of proof and evidence will be used, and how final determinations will be communicated.

2. Substantial delay in processing H-4 nonimmigrants.

In addition to the uncertain amount of paperwork and administrative burden, is the added factor of delay in sponsoring the admission of H-4 nonimmigrant nurses. Even after all the conditions and restrictions have been met according to the regulations to be proposed by the Secretary of Labor, there remains the issue of how much time and resources Labor Department officials have to actually review the evidence provided and make a final determination.

Under the well-established procedures of permanent labor certification the process ranges in various parts of the country from 4 to 18 months or more. Regretfully, much of this time is used with completed paperwork sitting on the desk of a government officer, awaiting its turn to be reviewed. Absent meaningful appropriations for new personnel, the imposition of new responsibilities to certify H-4 nonimmigrant nurses must be expected to further delay the process of permanent and temporary labor certification by the Department of Labor. Because the certification that the facility is meeting the new H-4 conditions lasts only one year, it is possible that obtaining and keeping H-4 sponsorship eligibility could be a constant, full-time endeavor each year. The problem of delay is especially serious at the beginning of the program, 9 months after the date of enactment of H.R. 1507. As introduced, the Secretary of Labor is not obliged to provide final regulations until 30 days prior to the beginning of the H-4 program. At the beginning of the H-4 program, H.R. 1507 would prevent any further petitions for H-1 professional nurses. Yet, it is difficult to believe that in 30 days from the time of final regulation to the beginning of the H-4 program, either the health care facility sponsors

would be able to prepare and complete their applications for certification of nurse shortage area/substantial disruption and certification of the facility-specific requirements relating to adverse affect, prevailing wage, and steps to recruit and retain. Even if the health care employers were able to turn these applications around within the 30 day period, one can only speculate how long it would take the Labor Department, with no additional personnel or other resources, to receive, review, and adjudicate petitions from all over the country. Absent any opinion of the Department of Labor, our collective experience tells us that hospitals must expect a 6-month or longer period in which the initial determinations could be made. During that time, they would be prevented by H.R. 1507 from sponsoring nonimmigrant nurses.

3. Uneven burden between differing institutions.

As proposed, the H-4 nonimmigrant requirements imposed by H.R. 1507 apply equally to health care facilities of all sizes and nature, including individual nurses assigned to home care responsibilities. AILA presumes no expertise or special knowledge of health care facility management or conditions. However, it stands to reason that the larger, most economically sound health care facilities will be best able to shoulder the new burdens and expense imposed by H.R. 1507 in securing nonimmigrant foreign nurses to supplement the U.S. workforce. As we read the proposals, and in the absence of Department of Labor regulations, it appears to us that the fulfillment of the conditions required will be about the same for all facilities, large or small, profitable or economically troubled. Of course, this situation exists under present law, and health care facilities with deeper pockets are better able to supplement their U.S. workforce by sponsoring H-1 nonimmigrant nurses. However, the relative ease of H-1 sponsorship, in comparison to the restrictions imposed on the new H-4 category, permit facilities of all sizes and conditions to compete for the available nursing talent. The imposition of new restrictions and conditions will be advantageous to facilities best able to shoulder the new economic burden in comparison to those facilities already operating on a thin margin.

4. Uncertainty of certification outcome and personnel decisionmaking.

The several layers of required certifications by the Department of Labor will, of course, inject increased uncertainty in health care facility planning for future personnel resources and needs. Under current law, health care facilities can reasonably rely on the availability to supplement the U.S. workforce when necessary with H-1 nonimmigrant nurses. After implementation of H.R. 1507's new H-4 nonimmigrant program, facilities will no longer be able to forecast from year-to-year whether foreign professional nurses can be sponsored to supplement the U.S. workforce because the certifications by the Labor Department must be renewed every 12 months. Only after certification has been obtained can the hospital be certain it may sponsor nonimmigrant professional nurses, and then only for the period remaining in the year of certification. Because health care facilities may find themselves having to begin new certification requests for the next year immediately upon receiving certification requests for the current year, continued uncertainty must be expected.

5. Governmental Administrative Burden and Expense

The H-4 nonimmigrant program will require substantial attention and effort by the agency personnel. Presumably, most health care facilities that now sponsor H-1 nonimmigrant nurses will seek initial qualification and annual requalification for H-4 sponsorship. These adjudications are to be performed by Department of Labor personnel, presumably at the various regional offices. Existing staff are already fully occupied with the present labor certification casework, hence the recruitment and hiring of new H-4 personnel must be envisioned. Whether the expense of this new program is borne by the government or the facilities, the public will ultimately have to shoulder the cost.

JUSTIFICATION FOR THE NEW RESTRICTIONS AND CONDITIONS OF THE H-4 NONIMMIGRANT NURSE PROGRAM

Given the expected expense and increased administrative burdens of the H-4 program, one might reasonably ask why, in the face of a pervasive nationwide shortage of 137,000 professional nurses, these new burdens are necessary. In the hope of better understanding the reasons for these new restrictions, let us examine several of the justifications provided for the new H-4 nonimmigrant program.

Justification 1: Restrictions on future sponsorship of nonimmigrant nurses will force hospitals to change recruitment and retention policies. This is the view that the sponsorship of nonimmigrant professional nurses should be used as a lever to force hospitals to change their policies as to wages, working conditions, recruitment, and retention so as to bring more U.S. workers into or back into the nursing profession. This justification presumes that the present nursing shortage is mostly the result of faulty policies adopted by health care facilities, and that simple changes in such policies will eliminate the pervasive nursing shortage. However, the facts and findings of recent reports on the nursing shortage indicate that it is a much more complex and difficult problem than simply faulty hospital personnel policies. While such policies have, in part, been found to contribute to the nationwide nursing shortage, the simplistic and moralistic view that health care facility management is the sole cause has been rejected. In our opinion, the proposals of H.R. 2111, which provide positive, affirmative programs to help health care facilities make the nursing profession more attractive to U.S. workers are preferable to proactive denying the availability of nonimmigrant professional nurses unless such measures are taken.

Justification 2: Nonimmigrant professional nurses are to blame for the nationwide nursing shortage. A least fortunate aspect of the current nursing shortage is, succumbing to the temptation to lash out at a scapegoat, is the view that the admission of several thousand nonimmigrant professional nurses annually has somehow caused the pervasive nationwide shortage of 137,000 nurse vacancies in a profession that employs 1.6 million professionals. Unfortunately, no reliable statistics have been kept of the number of nonimmigrant nurses admitted to the United States over the last decade. In fiscal year 1987, some 6,000 H-1 nonimmigrant nurses were admitted. Unfortunately, no reliable statistics of H-1 admissions for professional nurses have been

kept over the past 10 years. We do know that such admissions reached a record high in fiscal year 1987, reflecting the acute nature of the nursing shortage of some 6,000 nonimmigrant nurses. Admissions were much lower in preceding years when the nursing shortage was less acute. Fueled by frustration and impatience over the state of the nursing profession, allegations and accusations blaming foreign professional nurses for the present nursing crisis only served to fuel the subjective backlash against foreign nurses. In fact, there is no evidence that foreign nurses have caused or even contributed to the pervasive nationwide nursing shortage.

The Health and Human Services Commission on Nursing found that "[The current shortage of registered nurses] is primarily the result of an increase in demand as opposed to a contraction of supply." Nowhere is it suggested in the Commission's report that nonimmigrant nurses contribute to the nationwide shortage.

Similarly, the June, 1988 report of the Immigration and Naturalization Service on the H-1 program found that, even if the New York areas total employment of nurses are foreign professional nurses, "this relatively large employment of H-1 nurses is clearly responsive to a condition of severe labor shortage, and we could find no implication that American nurses in New York City or elsewhere suffer job displacement due to H-1 employment." Based on the report's analysis, which compared utilization of H-1 nonimmigrant nurses in several parts of the country, they concluded "that the concentration of employment of H-1 nurses in the New York City labor market area, which was by far the largest such concentration among any occupational group in any labor market area, had no adverse impact on the employment of American workers."

Justification 3: New restrictions on nonimmigrant nurses are the price for special immigrant status for foreign professional nurses presently in the U.S. Granting special immigrant status to foreign professional nurses in the United States, like extending their stay beyond the 5- or 6-year limit imposed by INS regulations, is clearly a benefit to the affected foreign professional nurses, the health care facilities who employ them, and the patients and others who will directly benefit from their services. This justification asserts that for each benefit received there must be a price paid. In this case, the price is new restrictions and burdens on future sponsorship of nonimmigrant nurses. Obviously, the price of new restrictions on nonimmigrant nurses will be considerably more expensive if the provision of special immigrant status to current nonimmigrant nurses proves politically unfeasible.

Quite separate and apart from the nursing profession and shortage, is the desire of some to impose restrictions and new barriers to H-1 nonimmigrant admissions in all occupations, but especially in the entertainment industry. This view holds that the 20-year policy of admitting professionals as H-1 nonimmigrants has been unlawful, and that new restrictions and structures to protect U.S. workers must and should be erected. Despite the factual finding of the INS report that there is generally no adverse impact on employment of U.S. workers as a result of H-1 nonimmigrant admissions, these forces are apparently seizing the opportunity to advance an agenda apparently aimed at preserving desirable levels of labor shortages or imposing a penalty on employers who have or will sponsor H-1 nonimmigrant professionals. Although the irony of imposing

the greatest restrictions in the occupational field of greatest shortage is apparent, the undeniable need to preserve an acceptable level of patient care and the inability to "export" hospital services make the nonimmigrant professional nurse procedures an attractive target. In other industries, measures to unduly restrict the availability of professionals and other highly-skilled workers to supplement the U.S. workforce can and have simply resulted in the removal of such industries outside the boundaries of the United States.

We understand that the Committee will be looking much more closely at these issues in the future, and we welcome the opportunity to more comprehensively develop and express our views and experiences on the subject. In the present instance, we are not convinced that U.S. health care facilities should be singled out for special new restrictions and burdens on the sponsorship of foreign nonimmigrant professionals.

SPECIFIC RECOMMENDATIONS ON THE H-4 NONIMMIGRANT NURSE PROGRAM

Although we are unconvinced of the need and desirability of imposing new restrictions and burdens on the sponsorship of nonimmigrant foreign nurses, we have a number of suggestions that, based on our collective experience, could make the program more workable and realistic.

STREAMLINE CERTIFICATION OF SUBSTANTIAL DISRUPTION, ADVERSE AFFECT, PREVAILING WAGE, AND STEPS TO RECRUIT AND RETAIN

As noted above, AILA is unpersuaded that new restrictions on nonimmigrant foreign nurses are in the national interest or will contribute to the alleviation of the nationwide nursing shortage. In an event, for whatever reasons this Committee may conclude that such restrictions should be imposed, we urge the Committee to ensure that the requirements and conditions finally enacted minimize the expense, administrative burden, and delay.

In our opinion, the most serious danger in enacting the new H-4 nonimmigrant program requiring Labor Department certification is the uncertain ability of the affected agencies to perform the required adjudications in a timely and unburdensome fashion. The Department of Labor certifying officers and Immigration and Naturalization Service Examinations personnel are already struggling to keep from falling further behind their current workload of responsibilities. As introduced, H.R. 1507 precludes the sponsorship and admission of nonimmigrant professional nurses until certification has been made by the Secretary of Labor on the points of substantial disruption without the foreign professional nurse, the absence of adverse affect, the payment of prevailing wage at the facility, and the taking of significant steps to recruit and retain U.S. nurses.

Based on all the facts before us, including the pervasive shortage of nurses, substantial wage increases across the country, proposed programs to assist and enlarge the nursing profession and the increasing demand for nursing care, we are confident that given enough time and resources, health care facilities will have no problem satisfying

the conditions imposed on H-4 nonimmigrant admissions. We strongly recommend that, rather than obliging employer-sponsors to wait until certification is received, that they be permitted to attest to the fulfillment of each of the requirements, by formal statement of affidavit of a responsible official at the hiring institution. Available resources at the Department of Labor and INS could then be devoted to post-audit of the statements of employer-sponsors to ensure the truthfulness of the representations contained in the application. Permitting the satisfaction of the conditions and requirements by attestation would virtually eliminate the delay injected by the proposed H-4 program and would alleviate the workload pressures of mandatory certification in all cases. Moreover, selective verification by the Labor Department would permit devotion of its limited resources to those instances where concerns are the greatest.

In addition, the post-audit verification approach decreases the problems caused by the subjective nature of the conditions and requirements to be fulfilled. For instance, what will Department of Labor adjudicators require to approve certification that a facility has "demonstrated that it has taken and is taking timely and significant steps designed to recruit and retain sufficient registered nurses"? H.R. 1507 suggests 4 significant steps that can be taken to meet this requirement but no indication is given whether any one or all of these steps are sufficient to meet the intended restriction. Although paying registered nurses at wages above the prevailing wage rate and the operation of a training program for registered nurses at the facility are objective and reasonably determinable, the other steps remain uncertain. What will the Labor Department consider to be *adequate* support services to free registered nurses from administrative and other non-nursing duties? What will Department of Labor adjudicators consider *reasonable* opportunities for meaningful salary advancement by registered nurses? What will they consider to be an adequate *opportunity* for training elsewhere if not provided at the facility?

Over time, it can be expected that a reasonable and predictable understanding of what it takes to fulfill these requirements will emerge. Unfortunately, the history of the permanent labor certification process does not engender confidence that this will take place promptly. In the meantime, health care facilities will be left to experiment and speculate as to what is required of them in order that they may be certified to sponsor nonimmigrant professional nurses. We again urge that if such conditions and restrictions must be imposed, that they not delay or unduly burden health care employers to the detriment of patient care.

PERMIT REINSTATEMENT OF EMPLOYED BUT OUT-OF-STATUS FOREIGN REGISTERED NURSES

As noted above, a number of experienced, foreign registered nurses are employed in the United States who have lost employment authorization and are no longer in lawful nonimmigrant status for a variety of reasons. The employment of many such out-of-status nurses is entirely lawful due to their "grandfathered" protection under the Immigration Reform and Control Act of 1986. Although these workers have violated U.S. immigration laws, the benefit of their nursing services to alleviate the current shortage is clearly in the national interest. We recommend that employers of out-of-status but qualified professional nurses be permitted to petition to reinstate such

individuals to lawful nonimmigrant status and begin the process of petitioning for immigrant permanent residence. Of all foreign professional nurses, this group is the most susceptible to payment below the prevailing wage and the least able to insist on working condition improvements, where appropriate.

ALTERNATIVES TO THE H-4 NONIMMIGRANT NURSE PROGRAM

In view of the considerable expense and administrative burden to both the public and private sector that the new H-4 nonimmigrant nurse program will require, it is appropriate to consider less drastic alternatives that may serve many of the purposes intended by H.R. 1507. While many such alternatives can be conceived, we believe that two suggestions are especially worthy of the sponsors' and the Committee's attention.

DIRECT THE INS TO EXTEND H-1 NONIMMIGRANT NURSES' STAY UNTIL ELIGIBLE FOR PERMANENT RESIDENCE

Broadly speaking, AILA believes that the real problem with regard to foreign professional nurses is the 5- or 6-year regulatory limit on H-1 nonimmigrant stays. Even in the face of the large nursing shortage, health care facilities have not petitioned for a undue or significant number of nonimmigrant nurses. In most cases, a petition for permanent residence under the 3rd or 6th preference category is filed for the H-1 nonimmigrant professional nurse and labor certification is available by pre-certification and the absence of adverse affect. At this point, the waiting game begins and the issue becomes whether the nonimmigrant nurse will reach the 5-year limit prior to obtaining permanent residence due to preference category and per country quotas.

Obviously, in view of the well-recognized shortage and need for foreign nurses to supplement the U.S. workforce at the present time, the simplest, least expensive, and least disruptive remedy would be a direction to the Justice Department that the pervasive shortage be considered an extraordinary circumstance warranting extension of lawful H-1 nonimmigrant status beyond 5 years and until such alien becomes eligible for permanent residence or ineligible due to malfeasance or leaving the nursing profession.

The Immigration and Naturalization Service could require that an immigrant preference petition be filed and Schedule A labor certification be obtained prior to granting such extensions. Perhaps even some of the new qualifications and conditions require for the proposed H-4 status could be required, not of every health care facility for every new nonimmigrant nurse, but only upon the necessity of an extension beyond the fifth or sixth year.

This approach was taken in 1988, when the INS reversed its position and granted a blanket sixth year extension for H-1 nonimmigrant nurses. In order to qualify for the blanket sixth year extension, health care facilities were required to demonstrate to the Service

their good faith efforts to recruit and retain United States nurses, such as the following: improve wages and working conditions; provide loans and scholarships

for in-house personnel, e.g., LPNs and nurses aides, who may desire to become nurses; increase support systems to nurses to relieve them of administrative and nonclinical duties...; and offer more flexible employment in terms of hours and types of patient care desired. (US INS, 31 May 1988)

In addition, the INS permitted the grant of "limited voluntary departure with work authorization not to exceed one year" beyond the sixth year for nurses employed by facilities that could demonstrate an emergent need and that had taken "the necessary steps to minimize their dependence on H-1 nurses."

In contrast to the certifications by the Department of Labor that would be required by the proposed H-4 nonimmigrant nurse program, the adjudication of these extensions were neither unduly burdensome or expensive to the government or the sponsor health care facilities.

In our opinion, this less burdensome approach is also beneficial in that it allows health care facilities to devote their attention and resources to affirmative efforts to recruit and retain U.S. workers rather than to the on-going responsibility to document the conditions and qualifications required by the proposed H-4 nonimmigrant program.

PROPOSAL TO ESTABLISH PRE-IMMIGRANT CATEGORY FOR FOREIGN PROFESSIONAL NURSES

In the alternative, AILA recommends that the Committee consider the establishment of a new category which, for the purposes of description, we will label a pre-immigrant status. It is quite obvious to professionals in the field that but for processing delays, and preference category and per country limitations, most foreign professional nurses could be admitted to the United States as immigrants with the required labor certification. Unfortunately, we cannot foresee the elimination of such delay, and it may be some time before the annual number of employer-sponsored visas is increased to meet current demand (some 75,000 to 80,000 per year). Even when the allocation of employer-sponsored visas is increased, continuing per country limitations will require delay in the granting of permanent residence particularly to natives of such over-subscribed countries as the Philippines.

It occurs to us that the establishment of an interim, pre-immigrant, admission category may be warranted. Such a category could be established for foreign professional nurses while the extensive nationwide shortage of U.S. nurses continues.

The outlines of a pre-immigrant program for foreign professional nurses could begin with a national or regional designation by the Department of Labor that a pervasive shortage of qualified professional nurses exists (clearly, this condition is now unquestioned by all quarters). During the period of the recognized nursing shortage, employer sponsors could be permitted to sponsor qualified professional nurses as "shortage worker pre-immigrants" as an alternative to H-1 nonimmigrant status. We would recommend that application for a shortage worker pre-immigrant constitute both a petition for relatively prompt admission of the needed worker similar to the admission of nonimmigrants, as well as a petition for immigrant status (under the 3rd or 6th

category) subject to labor certification (now available under Schedule A), preference category quotas, and per country limitation.

Unlike the present H-1 nonimmigrant category or the proposed H-4 nonimmigrant category, such pre-immigrants would be permitted to remain in the United States until obtaining permanent residence or becoming disqualified. Once admitted, they would not be subject to an arbitrary number of years nor would there be any doubt that they were on-track for permanent residence.

Naturally, to maintain pre-immigrant status, the foreign professional nurse would be required to continue employment as a registered nurse, and avoid committing acts that would render him or her excludable or otherwise ineligible for permanent residence.

Such pre-immigrants would not need to maintain an unrelinquished domicile abroad and the strictures INA §214(b), which presumes that every alien is an immigrant until the alien proves otherwise, would not be necessary. To avoid unduly tying such pre-immigrants to one employer, we would expect that, like H-1 nonimmigrants, the pre-immigrant nurse would be permitted to change employers.

We would also envision that some renewal of pre-immigrant status would be required from time-to-time, thus ensuring the pre-immigrant's continued occupation as a professional nurse.

We suggest that nurses already in the United States on the date of enactment be allowed to transfer to the pre-immigrant category, which could remove the need to grant special immigrant status as proposed in H.R. 1507.

We believe a pre-immigrant status is appropriate in that it directly relates to the existing shortage of U.S. workers, includes protection through labor certification of the U.S. workforce, but does not impose new restrictions and burdens on employer sponsors.

As a streamline alternative to H-1 nonimmigrant petitions and 3rd and 6th preference immigrant petitions, the pre-immigrant program would directly address the present nursing shortage without imposing new costs on the public or private sector. Because the pre-immigrant program takes elements from existing procedures, there is no reason to believe that the number of nurse pre-immigrants would be any greater than the number of H-1 nonimmigrant nurses, nor that the rising tide of wage increases and other working condition benefits would be smothered.

The pre-immigrant category could also be reserved solely for H-1 nurses who are the beneficiaries of labor certification and an immigrant preference petition but who have reached the 5th year of their H-1 nonimmigrant stay and, at least under current, would no longer be eligible for extension of their H-1 nonimmigrant status.

CONCLUSION AND SUMMARY

In conclusion, AILA shares the universal concern over the pervasive professional nursing shortage in the United States. As a result of this shortage, some reliance on foreign professional nurses at this time is both appropriate and advantageous to the national interest.

Contrary to the opinions of some, but consistent with the actual evidence, we concur with the findings that foreign professional nurses, either as nonimmigrants or permanent resident immigrants, have not had an adverse affect on the U.S. nursing profession and that they are a symptom, not a cause, of the current nursing shortage.

We do not believe that the admission of 5,000 or 6,000 nonimmigrant nurses nor the grant of permanent residence to several thousand foreign professional nurses each year, in the face of a pervasive nationwide shortage of 137,000 professional nurses is a substantial problem that needs far-reaching remedies. In fact, we prefer the inexpensive and less burdensome relief of simply permitting extensions beyond 5 years of nonimmigrant or pre-immigrant nurses until qualified for permanent residence under preference category and per country quotas.

We are mindful of the uncertain political feasibility of granting across-the-board special immigrant status to nonimmigrant nurses now in the United States, and we recognize that this remedy, as proposed, would not benefit a number of the foreign registered nurses now employed in the United States.

While AILA understands and respects the intent of the proposed H-4 nonimmigrant category for professional nurses, we are concerned that, as proposed, it could result in considerable expense, delay, and uncertainty for health care facilities already struggling to maintain adequate levels of patient care. We recommend that less burdensome amendments to the H-1 program be considered or that more comprehensive reform, such as the establishment of a pre-immigrant category, be explored. At minimum, we urge the Committee to consider amendments to H.R. 1507 that will minimize the burden to employer sponsors of foreign professional nurses.

We applaud the positive, affirmative approach of H.R. 2111 which seeks to encourage the recruitment, retention, and training of U.S. registered nurses through funding of a variety of direct programs and demonstration projects.

Finally, we understand the difficulty and complexity of these issues, and we look forward to working with the Committee and other interests including health care facility management, nurses professional societies, and other labor organizations, to develop a rational, well-balanced proposal to address the situation of nonimmigrant foreign nurses and the U.S. nursing shortage.

I would be pleased to take any questions from the Committee now or following this hearing.



AMERICAN IMMIGRATION LAWYERS ASSOCIATION

AN AFFILIATED ORGANIZATION OF THE AMERICAN BAR ASSOCIATION

STATEMENT OF WARREN R. LEIDEN AMERICAN IMMIGRATION LAWYERS ASSOCIATION TO THE SUBCOMMITTEE ON IMMIGRATION, REFUGEES, AND INTERNATIONAL LAW REGARDING THE NURSING RELIEF ACTS

--Summary--

AILA members represent a wide range of employers that sponsor foreign professional nurses for both nonimmigrant and immigrant status.

Both sponsors offered their proposals to encourage discussion, debate, and compromise. The comments and recommendations of this statement are offered in that spirit.

The causes and remedies for the pervasive shortage of professional nurses in the U.S. include both "demand-side" and "supply-side" factors.

- ** Employment of foreign professional nurses is not a cause of the shortage, but rather a symptom of this complex problem.
- ** Remedies for the shortage should primarily emphasize recruitment, retention, and education of U.S. workers for the nursing profession.
- ** Employment of foreign nurses will not significantly increase the overall supply of RNs, but they do prevent the shortage from being worse than it already is.

PRESENT LAW

Foreign nurses qualify for permanent residence under 3rd or 6th preference with Schedule A labor certification (pre-certified). Processing and quota wait combined take almost two years, but over 4 years for Filipino nurses.

Foreign nurses also qualify for H-1 nonimmigrant status, but INS regulations now require departure after 5 or 6 years. Some whose stays expired 1987 - 1989 were extended to 12/31/89.

H.R. 2111 -- THE EMERGENCY NURSE SHORTAGE RELIEF ACT OF 1989

Establishes a number of programs to encourage recruitment, retention, and education for the nursing profession.

Directs the Attorney General to provide H-1 nonimmigrant nurses

nursing crisis areas with at least a sixth year extension if Secretary of Labor certifies their continuing employment will not adversely affect wages and working conditions of RNs in the U.S.

H.R. 1507 -- THE IMMIGRATION NURSING RELIEF ACT OF 1989

Grants special immigrant status to certain H-1 nonimmigrant nurses who remain in status and employed as RNs on date of enactment and who receive approved labor certification.

Makes foreign nurses ineligible for H-1 status but establishes new H-4 nonimmigrant nurse program for five years:

- ** H-4 nurses must meet qualifications now required by regulation.
- ** H-4 nonimmigrant employer-sponsor must obtain Secy of Labor certification that:
 - there would be substantial disruption of health care without the services of the H-4 nonimmigrant nurse;
 - employment of the H-4 nurse will not adversely affect wages and working conditions and H-4 nurse will be paid prevailing wage at the facility;
 - facility is taking significant steps to recruit and retain U.S. nurses;
 - there is no strike or lockout and H-4 nurses are not intended to influence a union election; and
 - notice of H-4 petition provided to bargaining representative or is posted if there is no bargaining representative.

Secy of Labor certifications are good for one year, and facilities must seek annual re-certification as to the adverse affect, prevailing wage, and significant steps to recruit and retain.

COMMENTS ON H.R. 1507 GRANT OF SPECIAL IMMIGRANT STATUS

Recommend that special immigrant status be granted to those in lawful H-1 status on cut-off date (prefer Jan. 1, 1989) and whose H-1 status has not expired by date of enactment.

Recommend clarification that the required labor certification is satisfied by Schedule A pre-certification.

Recommend extension or other relief for nurses whose H-1 status expires 12/31/89 in order to complete processing for special immigrant status.

Recommend including in special immigrant grant those foreign nurses who are not in status, including those who did not qualify for the 1988 extension and "grandfathered" nurses.

If grant of special immigrant status proves unfeasible, recommend interim or pre-immigrant status to carry 5th/6th year H-1 nurses until their preference category and per-country quotas are met for permanent residence.

COMMENTS ON H.R. 1507 NEW H-4 NONIMMIGRANT NURSE PROGRAM

Despite pervasive shortage of professional nurses, the new H-4 nonimmigrant program imposes new conditions and restrictions that, compared with present law, are likely to result in increased paperwork and administrative burdens, substantial delay, uneven burdens on different facilities, increased uncertainty in personnel decision making, and additional government personnel and expense.

The expected expense and increased administrative burden of the H-4 program appear to be justified by the view that restrictions on nonimmigrant nurses will force hospitals to recruit and retain U.S. nurses, that nonimmigrant nurses are to blame for the nursing shortage, and that the new restrictions are the price for the grant of special immigrant status for foreign nurses in the U.S.

RECOMMENDATIONS TO IMPROVE THE H-4 NONIMMIGRANT NURSE PROGRAM

The expense and delay of the H-4 program could be reduced by permitting facilities to attest to the fulfillment of the requirements, rather than having to wait for Labor Dept Certification.

The Labor Dept could audit selected facilities later, permitting more effective concentration of resources and better judgments on the subjective qualifications.

Experienced, foreign registered nurses who fell out of status or lost employment authorization should be re-instated to lawful nonimmigrant status.

ALTERNATIVES TO THE H-4 NONIMMIGRANT NURSE PROGRAM

The simplest, least expensive remedy is to direct the INS to extend lawful H-1 nonimmigrant status until the nurse qualifies for permanent residence.

INS took this extension approach in 1988 and even required good faith efforts to recruit and retain U.S. nurses.

A more comprehensive solution is to establish an alternative "pre-immigrant" status for nurses while the shortage remains so pervasive.

A "pre-immigrant" program could include:

- ** Initial and periodic certification of shortage of professional nurses (like current Schedule A pre-certification).
- ** Pre-immigrant petition would constitute both application for admission in non-permanent status and application for permanent residence under 3rd or 6th preference.
- ** Pre-immigrant nurses would be permitted to remain in the U.S. to work in the profession until obtaining permanent residence or disqualification.

A pre-immigrant program would combine the processing and adjudication of the nonimmigrant and immigrant statuses, thus streamlining the present procedures for both the Government and the employer-sponsor.

The pre-immigrant status could also be implemented only for H-1 nurses who reach the 5th or 6th year limit of their nonimmigrant stay.

CONCLUSION

AILA concurs with the findings of recent studies that foreign professional nurses have not had an adverse affect on the U.S. nursing profession and are a symptom, not a cause, of the current shortage.

The simplest, least expensive solution to the situation of nonimmigrant nurses is to direct extension of their status until eligible for permanent residence under the category and per-country quotas.

If changes to nonimmigrant program are deemed necessary, they should be crafted so as to minimize delay, expense, and undue administrative burden.

Mr. MORRISON. Mr. Bean.

STATEMENT OF FRANK D. BEAN, DIRECTOR, POPULATION
STUDIES CENTER, URBAN INSTITUTE

Mr. BEAN. Thank you.

I am pleased to have the opportunity to testify about H.R. 1507, the Immigration Nursing Relief Act of 1989. I am not an expert on the nursing profession, nor on conditions in the United States that might have contributed to the development of shortages of nurses. For over a decade, however, I have been studying the labor market aspects of both legal and illegal immigration into the United States, first as a demographer at the University of Texas, from where I am on leave as Director of the Population Research Center, and now as codirector of the program for research on immigration policy, a joint program of research and public policy evaluation at the Urban Institute and the Rand Corp.

The nursing shortage, if it is appropriate to use that term in this instance, is of special interest because it provides an illustration of a phenomenon that many observers fear might become more widespread in the United States in the future. The concern is that shortages of entry level workers in general and of certain kinds of highly skilled workers, like nurses in particular, might increasingly develop. In other words, the current shortage of nurses may be a harbinger of things to come. Hence, it is instructive to raise a few broader questions about the relationship between immigration and labor shortages. The consideration of these, in turn, may have implications for the nursing situation.

In thinking about using immigration to deal with labor shortages, three important questions need to be posed. These are: One, do labor shortages really exist? Two, if such shortages exist, can immigration help to reduce labor shortages? And, three, if immigration can contribute to reducing labor shortages, are certain kinds of immigration more effective than others in doing so?

Do labor shortages really exist? Some economists argue that there is no such thing as a labor shortage, only shortfalls of labor at prevailing wages. The argument would be that if wages were raised, the shortages would disappear. Even if this argument were true—and I am not sure it is valid in any but the most theoretical sense—it begs the question of how long it would take for the shortage to be eliminated. In the case of an occupation like nursing, which requires lengthy training, it might take years to generate an increased supply of new nurses. Training new nurses might be the only way to alleviate a shortage if those persons who had left the profession had done so for reasons having little to do with wages, thus making them unlikely to come back because of increased pay. In short, even if nurses were paid a lot more, the shortage of nurses might not disappear overnight. The current deficit of nurses in the United States thus provides a powerful illustration of the fact that labor shortages are often real. They exist in ways that really matter.

Can immigration or temporary workers help reduce labor shortages? If immigrants or temporary workers can be brought into the United States to fill a given occupational shortage faster than new

workers can be trained, then the answer to this question is "yes". Even in this case, however, it must be recognized that relying on immigration or temporary workers to educe labor shortages may have consequences that extend far beyond the reduction of the shortage. This is perhaps best illustrated by a comment a West German official made a few years ago about that country's guest worker program. He said: "We thought we were getting workers, but what we got instead were people."

What this official meant was that workers are more than just employees. As people, they have families, children and friends. They establish roots. They become embedded in communities. The broader context within which immigrant or temporary workers exist often gets overlooked when immigration policy is viewed merely as a tool of labor policy. So while immigrants or temporary workers may indeed reduce labor shortages, policies narrowly targeted at achieving such ends will inevitably have longer run consequences. This was illustrated by our Nation's experience with the bracero program after World War II, when many temporary workers ended up becoming permanent settlers many years later.

Are certain kinds of immigration more effective in reducing labor shortages than others? Sometimes it is assumed that persons admitted to the United States as immigrants because they qualify on the basis of family reunification criteria do not perform as valuable and economic role as persons admitted on the basis of occupational or skill criteria. This assumption may be a mistake. Many of those who enter the country under family related criteria also work. Unfortunately, the kind of information needed to compare the economic characteristics and consequences of persons admitted on the basis of family criteria with those of persons admitted on the basis of skill or occupational criteria is not presently collected. Hence, it is impossible to say with certainty that the one kind of immigrant is better for the economy or the country than the other.

As our experience with the bracero program has shown, persons admitted in order to reduce a labor shortage in a given occupation or industry often find a way eventually to adjust their status, which means they may end up working in a different occupation or industry than the one in which the shortage existed. While policies promoting such admissions may help with labor shortages in the short run, they do not deal with the basic conditions giving rise to the shortages in the first place. In fact, such policies may even exacerbate labor problems in the long run if they make it easier to postpone grappling with the conditions that caused such shortages.

The broader issue is whether the United States, because of past demographic changes that will soon reduce the number of entry-age workers, may confront labor shortages in general over the next 10 to 20 years. If so, and if increased immigration is seen as a viable policy response to such shortages, then the issue is whether immigration should be targeted toward the occupations and industries experiencing the greatest shortages or whether nontargeted immigration—whether it be family reunification-based or skills-based—should be increased, letting the normal operations of the economy operate to channel persons into particular jobs. Right now, the findings of research do not provide an answer about

which of these alternatives might be the more efficient and the more economically beneficial for the country.

[The prepared statement of Mr. Bean follows:]

PREPARED STATEMENT OF FRANK D. BEAN, THE URBAN INSTITUTE

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labor shortages? and (3) If immigration can contribute to reducing labor shortages, are certain kinds of immigration more effective than others in doing so.

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If immigrants (or temporary workers) can be brought into the United States to fill a given occupational shortage faster than new workers can be trained, then the answer to this question is "yes." Even in this case, however, it must be recognized that relying on immigration (or temporary workers) to reduce labor shortages may have consequences that extend far beyond the reduction of the shortage. This is perhaps best illustrated by a

comment a West German official made a few years ago about that country's guest worker program. He said: "We thought we were getting workers, but what we got instead were people."

What this official meant was that workers are more than just employees. As people, they have families, children and friends. They establish roots. They become embedded in communities. The broader context within which immigrant (or temporary) workers exist often gets overlooked when immigration policy is viewed merely as a tool of labor policy. So while immigrants or temporary workers may indeed reduce labor shortages, policies narrowly targeted at achieving such ends will inevitably have longer-run consequences. This was illustrated by our nation's experience with the Bracero program after World War II, when many temporary workers ended up becoming permanent settlers many years later.

Are certain kinds of immigration more effective in reducing labor shortages than others?

Sometimes it is assumed that persons admitted to the United States as immigrants because they qualify on the basis of family re-unification criteria do not perform as valuable an economic role as persons admitted on the basis of occupational or skill criteria. This assumption may be a mistake. Many of those who enter the country under family-related criteria also work. Unfortunately, the kind of information needed to compare the economic characteristics and consequences of persons admitted on the basis of family criteria with those of persons admitted on the basis of skill or occupational criteria is not presently collected. Hence, it is impossible to say with certainty that the one kind of immigrant is better for the economy or the country than the other.

As our experience with the Bracero program has shown, persons admitted in order to reduce a labor shortage in a given occupation or industry often find a way eventually to adjust their status, which means they may end up working in a different occupation or industry than the one in which the shortage existed. While policies promoting such admissions may help with labor shortages in the short-run, they do not deal with the basic conditions giving rise to the shortages in the first place. In fact, such policies may even exacerbate labor problems in the long-run if they make it easier to postpone grappling with the conditions that caused such shortages.

The broader issue is whether the United States, because of past demographic changes that will soon reduce the number of entry-age workers, may confront labor shortages in general over the next ten to twenty years. If so, and if increased immigration is seen as a viable policy response to such shortages, then the issue is whether immigration should be targeted toward the occupations and industries experiencing the greatest shortages, or whether non-targeted immigration (whether it be family re-unification-based or skills-based) should be increased, letting the normal operations of the economy operate to channel persons into particular jobs. Right now, the findings of research do not provide an answer about which of these alternatives might be the more efficient and the more economically beneficial for the country.

Mr. MORRISON. You made us listen to all of that to say there wasn't an answer?

Mr. BEAN. I beg your forgiveness.

Mr. MORRISON. I would like to pursue that point a little bit further.

Mr. Bean, you sort of propose a series of questions. They ought to be the questions that we answer in the context of the legal immigration debate that has been in the Congress for the last couple of years. It turns on some of the questions that you are presenting as to how ought we integrate the issue of labor force.

Do you have any suggestions for what we ought to be asking of the Department of Labor or someone to give us the tools over time? We are not going to have the answers within the timeframe that we are going to be asking, the political judgments pressed upon us. Is there ongoing data collection that doesn't currently exist, or kind of analysis or policymaking that this Government doesn't engage in that other governments engage in more successfully or that this Government ought to try to engage in?

Mr. BEAN. Just a couple of comments. We are trying to get research underway now to look at this question of whether the labor characteristics and consequences of persons who come to this country and immigrants entering under the family criteria are different from the ones who come in under the occupation or skilled type criteria. Sometimes it is argued that people who come in on one of the family presence criteria is not as highly skilled.

The point I would like to emphasize is right now we don't know because we don't have any way of finding out. The way we are trying to get at it is trying to use some data that the Immigration and Naturalization Service collected, used to collect, on illegal immigrants to this country. These data were stopped, this program was stopped, the I-53 registration program was stopped in 1981 because, as I understand it, the Immigration and Naturalization Service concluded these data were not useful. Now it turns out there may be, they may be the only kind of data that could be used to address this sort of fundamental problem.

In general, it seems to me, I think, that we ought to be cautious and careful in making our immigration policy especially when making claims that it will solve certain kinds of labor problems.

On the question of illegal immigration, which I have done a lot of research on, the—what we found in our research studies is it is very important to make a distinction between legal and illegal immigrants. The only research that has been done so far that looks at the impact of illegal immigration, as well as legal, that we have recently concluded in the last couple of years, what we find is that neither kind of immigration has a very large labor market impact, that is to say has much of an effect on the wages and employment of other groups of workers, whether it be Hispanics, blacks or what have you.

But that legal immigration seems to have, to depress slightly, and slightly is important, depress slightly the wages of other workers. And illegal immigration seems to increase slightly the wages of other workers, suggesting that there might be some kind of complementary in the production process. Maybe illegal aliens are doing the scut work and increasing productivity slightly. The opposite is

true, however, at least as indicated in our research, for legal immigration.

The point is that one can't generalize on the basis of the research much without making a distinction between different kinds of immigration.

Mr. MORRISON. Mr. Smith.

Mr. SMITH of Texas. Mr. Bean, thank you for your excellent analysis as well.

Mr. Chairman, did you get the answer to your question?

Mr. MORRISON. My time is up.

Mr. SMITH of Texas. I think it was an excellent analysis. I say that not just because you are from the University of Texas. You are taking 1 year or 2 off from the institute?

Mr. BEAN. Yes, sir.

Mr. SMITH of Texas. This past weekend I read a publication entitled, "The Fourth Wave," put out by the institute, which is excellent, about immigration in California.

I am going to go to Mr. Leiden, if I might, and ask him a question, more technical question. This is in regard to H.R. 1507. Under that bill and H-4, nonimmigrant employer sponsor must obtain certification and will not adversely affect wages and working conditions, and so on.

It strikes me, based on the testimony we have heard today, that some of the very areas where there is a greater shortage, for instance, metropolitan areas like New York, there is also the most precise testimony of wage depression. That being the case, under a law like this and under wage certification like this, how is the Government ever going to be able to get foreign nurses to areas where there are shortages of nurses if those are the same areas where wages might be depressed by the foreign nurses?

Mr. LEIDEN. I think it is really a matter of opinion of the depression. Even on the labor union panel, I think there was disagreement.

Mr. SMITH of Texas. There was no disagreement because all four in their written testimony talked about depressed wages.

Mr. LEIDEN. I have not studied their written testimony.

Mr. SMITH of Texas. Take my word for it.

Mr. LEIDEN. I will. It does not surprise me that they said that. In fact, the studies even in New York where nonimmigrant nurses may constitute 20 to 25 percent, they found there is an effect—the Allen report, where they found there were 10 to 20, 25 percent of the work force were nonimmigrant nurses—they found there was no adverse effect on the working conditions of U.S. workers.

The HHS Commission on Nursing, though not going deeply into wages, didn't make any finding that foreign nurses, whether immigrants or nonimmigrants, contributed to either the adverse conditions that have come about in the nursing profession. I am not sure I rally agree with that point.

Mr. SMITH of Texas. You would disagree with the former four witnesses?

Mr. LEIDEN. I guess I would. Even after you see how many foreign nurses there are, there is still a 15- to 25-percent vacancy rate in positions there. Even if 10 percent, 15 percent, 25 percent were nonimmigrant nurses, I would think is a job vacancy rate of 15 to

25 percent has got to drive wages in a way that they are not undercutting. I am no labor economist, and I don't pretend to know that.

We see things on a much more tree level instead of a forest level. My members say their clients are paying the prevailing wage and then some. The nonimmigrant nurses, for them they have to pay their legal fees and processing fees.

Mr. SMITH of Texas. You don't see a problem with the labor certification described under 1507?

Mr. LEIDEN. I don't think the facilities would have a problem satisfying them. I think it is the procedures that they have to go through. They have to do that—you know, right now even for permanent immigration, its schedule A precertification recognizes that shortage.

Mr. SMITH of Texas. It seems to me that there was going to be a major problem satisfying that just on the basis of conflicting testimony. You are saying no wage depression for individuals. You testified that there was wage depression. I am saying it seems to me that is a key signal being sent to the Government as to whether or not they should or should not certify the foreign nurses.

Mr. LEIDEN. I am speaking just to the nursing profession. I am familiar with some of the studies, and they were more general. On specific points, I think nurses will not have trouble. I don't think anyone in the discussions we have had, anyone believes that they will have trouble satisfying that requirement in theory. It is just on paper and how long it takes. That is the problem.

Mr. SMITH of Texas. Thank you.

Mr. MORRISON. I want to thank you very much.

[Whereupon, at 2:45 p.m., the subcommittee adjourned, to reconvene subject to the call of the Chair.]

APPENDIX

MATERIAL SUBMITTED FOR THE HEARING



Raritan Bay Medical Center

530 New Brunswick Avenue, Perth Amboy, New Jersey 08861 • (201) 442-3700

May 24, 1989

The Honorable Bruce A. Morrison
Chairman, Subcommittee on Immigration,
Refugees and International Law
Rayburn Building
B370B
Washington, DC 20515

Dear Mr. Chairman:

As Vice President of Nursing at Raritan Bay Medical Center and as a representative of the New Jersey Hospital Association and its member hospitals' Directors of Nursing and Staff, I would like to take this opportunity to highlight key points regarding the shortage of nurses that has reached critical proportions in New Jersey and the nation and to underscore the importance of retaining foreign nurses in our hospitals during this critical period.

The reasons for the nursing shortage you've read about - low pay, difficult working conditions and increased alternatives for women in today's marketplace. Clearly, salary is an issue that has contributed to the current crisis, resulting in a diminished applicant pool for nursing programs concurrent to a rising demand for nursing services. Hospitals find it difficult not only recruiting, but retaining nurses on staff. Most recent hospital association statistics show nearly 17 percent of the state's 119 hospitals' budgeted nursing positions unfilled.

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Perth Amboy, New Jersey 08861
(201) 442-3700

Old Bridge Division
One Hospital Plaza
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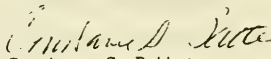
A teaching affiliate of the University of Medicine and Dentistry of New Jersey - Robert Wood Johnson Medical School

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During the past two years, NJHA has worked diligently to resolve these problems. Four nursing work groups, comprised of representatives from acute and long-term care facilities, professional nursing organizations and state agencies, were formed to study and recommend initiatives to reduce and ultimately, eliminate the nursing shortage. As a result of these work groups, the Nursing Resource Center, an information and recruitment service, was established, and nursing school enrollments increased approximately 25 percent in 1988. This is a beginning.

Mr. Chairman and members of the subcommittee, we are now seeking your support and sponsorship of legislation to protect the status of foreign nurses beyond December, 1989 and to grant permanent residency status to those H-1 visa nurses who have served in our hospitals with such dedication at a time when the demand for nurses has been at an all time high. The continuing changes in healthcare will only reinforce this demand; therefore, this foreign nurse population is vital to the maintenance of this crucial, professional resource. Thank you for your consideration.

Sincerely,


Constance S. Patten
Vice President/Nursing

CSP/gmp

PREPARED STATEMENT ON THE IMMIGRATION NURSING RELIEF ACT OF 1989

PRESENTED TO

THE SUBCOMMITTEE ON IMMIGRATION, REFUGEES,
AND INTERNATIONAL LAW
CONGRESS OF THE UNITED STATES
2237 RAYBURN OFFICE BUILDING
WASHINGTON, D.C. 20515

SUBMITTED BY:

DARLENE COX CHEANEY
Associate Administrator for Nursing
University of Medicine & Dentistry
of New Jersey
University Hospital
Department of Nursing

May 24, 1989

Mr. Chairman and members of the committee, thank you for this opportunity to testify.

My name is Darlene Cox Cheaney, and I represent the University of Medicine and Dentistry of New Jersey-University Hospital.

The University is a statewide institution with six schools on three campuses. University Hospital, located in Newark, is the core teaching facility of the New Jersey Medical School and the state's largest public hospital.

The hospital is a 518-bed unit that serves as a referral center for New Jersey and as the "family physician" for residents of Newark. Each year, more than 127,000 people use our inpatient and outpatient services.

University Hospital is designated as a Level I Trauma Center and as a Level III Perinatal Center. Other specialized, regional services include: the New Jersey Cancer Center, a Neurosurgical Intensive Care Unit, a Comprehensive Epilepsy Center and a Pain Management Center. Physicians here recently performed New Jersey's first liver transplantation.

I am here today to ask for your support of the Schumer Bill, H.R. 1507, known as the "Immigration Nursing Relief Act of 1989".

As the Associate Administrator for Nursing, I am responsible for directing more than 900 nursing employees, of which 450 are registered nurses. Eighty-seven of these RNs are foreign-born and educated, however, they have passed all requirements and licensing examinations to practice in the United States, specifically in the state of New Jersey.

New Jersey hospitals are now operating at a 17 percent nursing-vacancy rate for registered nurses.

Although University Hospital offers a comprehensive salary and benefits package, we are unable to attract new nurses by offering the high salaries that private and wealthy hospitals can afford to pay. As a result, we have had to rely heavily upon recruitment abroad to provide the necessary care and services.

University Hospital and other hospitals in New Jersey that utilize foreign nurses are faced with losing many of these nurses. If this bill is rejected, our hospital stands to lose 68 nurses - 34 by December 31, 1989, and an additional 34 by December 31, 1990. Consequently, our patients will suffer, and services and programs will be cut back or closed.

We are distressed because many of these nurses are employed in units where recruitment has been extremely difficult and where extensive training and experiences are required, for example, our intensive care units, our operating and recovery rooms, and our emergency services department.

University Hospital is not alone in experiencing these employment problems; there is now a national shortage of registered nurses to staff these types of units.

Our foreign nurses receive the same compensation and benefits packages as other nurses. They are not being employed to save money, but because they are excellent practitioners who are desperately needed.

Newark is New Jersey's largest city. Although it is currently undergoing a strong renaissance, the attractiveness of Newark as a viable, exciting workplace for nurses have not yet occurred.

The economics of Newark present some problems in recruiting and retaining qualified RNs to work at University Hospital. For example:

*University Hospital treats a large number of AIDS patients; our statistics show that 43 percent of our tested hospital population - excluding children - were diagnosed with some form of the AIDS virus. Many nurses, for a number of reasons, simply do not want to care for patients with AIDS. Those who do must face the challenges of a devastating disease for which there is no cure. Caring for patients with AIDS is exhausting, both physically and emotionally, and leads to rapid burn-out.

*University Hospital is the primary physician for numerous underprivileged Newark residents; often the medical care they receive is through our outpatient clinics and the emergency room. Frequently, these patients' conditions have gone untreated for long periods of time. Often, they are hospitalized, and their multifaceted clinical and social issues must be addressed.

Last year, when our foreign nurses were granted a temporary, one-year extension of their H-1 visas, University Hospital's executives were told to step up our recruitment-and-retention efforts for American nurses so that we would not rely heavily on the foreign nurses.

I assure you, University Hospital has done this. In the last two years, we have:

*upgraded a comprehensive compensation and benefits package;

*encouraged better working relationships between nurses and the medical community;

*established on-site educational opportunities including in-service continuing education and undergraduate-degree courses given on campus;

*employed a variety of levels of nurse clinicians, including clinical nurse specialists and nurse practitioners, to recognize the expanded roles of nursing;

*identified nursing responsibilities that were reassigned to others in support services to free RNs for direct patient care;

- *strived to provide a professionally attractive work environment;

- *applied for grant money to explore restructuring nurses' work environments.

Despite these sincere efforts, University Hospital's nursing-vacancy rate remains at 17 percent.

University Hospital recognizes H.R. 1507 is only a temporary measure to help ease nursing shortages, but I ask you to consider our position.

All new nurses at University Hospital undergo an orientation program and a period where they work under the direction of a preceptor, a nurse with significant experience and expertise. In intensive-care units, the emergency room, the operating rooms and units with AIDS patients, this orientation and preceptor program often lasts eight to 12 months until such time when the nurse can practice comfortably and independently of preceptors.

Many of our foreign recruits are employed in these critical-care areas. If they are denied permanent residencies, University Hospital will lose quality patient care and the investment of expensive orientation costs. Our nursing-vacancy rate will increase significantly.

If H.R.1507 is not passed, we will lose 34, or approximately eight percent of these registered nurses by December 1989 and another 34, for a total of 16 percent, by December 1990.

The issue is crucial because 42 of our beds are currently closed due to the nursing shortage. The loss of 34 nurses by the end of this year means we'll be forced to cut services and to close immediately 11 additional critical-care beds and/or 60 medical-surgical beds.

Our patients, their families and our community cannot afford this.

Thank you for this opportunity to speak.



FILIPINO NURSES ORGANIZATION (FNO)

c/o Philippine Center for Immigrant Rights (PHILCIR)
1472 Broadway Suite 822 NY, NY 10036
Tel. No. (212) 221-4532

STATEMENT BY THE FILIPINO NURSES ORGANIZATION TO

THE HOUSE JUDICIARY COMMITTEE

SUBCOMMITTEE ON IMMIGRATION REFUGEES AND INTERNATIONAL LAW

May 31, 1989

EXECUTIVE COMMITTEE

Mitzi Laurente R.N. LEA LIWANAG R.N. BLBERT T. RAMIREZ R.N. LET STA. MARIA R.N.

STAFF : Tony Abad R.N. Tatess Abad R.N. Elma Cabanayan R.N. Remy Leano R.N. Ruby Macabuhay R.N.
Butch Navarro R.N. Chris Quintio R.N. Therese Perez R.N. Lanel Sabater R.N.



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HOW CAN NURSES CARE FOR OTHERS WITHOUT CARING FOR THEMSELVES ?

THE HEARING ON H.R. 1507 IS A STEP TOWARDS ANSWERING THIS QUESTION

I. Background of the Problem

A. STATISTICS :

The end of 1988 has left the critical nursing shortage in the United States unresolved.

The American Hospital Association reports that the RN vacancy rate shot up to 13.6 % from a mere 6.3 % in 1985. According to reports, the health care system needs 300,000 nurses to function up to par. Such figures are similar to the levels of the last national nursing shortage of 1979, sources indicate. The Greater New York Hospital Association adds "the picture is further complicated by...AIDS."

Meanwhile, many schools face declining admissions, enrollments and graduations.

B. ANALYSES :

Of significant note is the effect of such shortage on the already understaffed, overworked and underpaid nurses, coming from working class families who are coping with the lack of a career ladder and prestige in nursing. These nurses, 97 % of whom are women are also engaged in the battle for comparable worth or pay equity.

What are the roots of this crisis?

Federal cost-cutting measures in the Medicare program during the early 1980s tightened the length and type of hospital stay allowed to Medicare patients. This increased the percentage of patients in hospitals who required intensive and serious care as compared to the greatly reduced number of short-stay patients.

To make up for the decreased funding, hospitals implemented cost-cutting measures that included freezing nurses' salaries.

The result was that many qualified nurses were working more shifts on more demanding, critical and intensive care wards for less money. They began to leave the health care system in large numbers and enrollments declined.

The nurses imported by the hospitals to ease the shortage, now, under the law have to stay only for five years after which they must return to the home country for one year and then reapply if they wish to re-enter the US workforce.

EXECUTIVE COMMITTEE

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Butch Navarro R.N. Chris Quinio R.N. Therese Perez R.N. Lani Sabater R.N.

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The implications here are staggering.

Eventually, in the face of the dwindling supply of domestic nurses and the constant turn-over of foreign nurses, the United States will have a workforce that is severely stressed, hesitant to confront management over labor issues, and unable to avail of pension plans, seniority pay and other benefits for more permanent workers.

The easy accessibility, availability and acquiescence of foreign workers will continue to be exploited by a management that is constantly reducing costs.

Meanwhile, the risks to patient care are enormous.

THE FOLLOWING ARE TESTIMONIALS .

- a) "I remember working on a med-surgical floor on nights in the third largest hospital in New York. I had as many as twenty (20) patients in my district with so many parrenteral nutrition and antibiotics to give the AIDS patients, fingersticks with insulin coverage in am for the diabetics, intakes and outputs to do ; if ever we got our 30-minute break, I ended up with forty patients! I usually stayed another 2 hours for charting and documentation ! " -staff nurse
- b) "I take care of babies in the neonatal intensive care unit. Everytime I would go to work and see the familiar outline of the hospital my stomach would turn over in apprehension as I thought of having to care for four (4) tiny babies with so many tubes in and out of them; I knew I had to check the vital signs (temperature, heart rate, respirations, blood pressure) every two hours but in an eight-hour shift I could only do it 2-3 times. The ideal nurse-baby ratio is 1:1. I prayed to God that nothing would happen to my license because my brother was depending on me to go to school. It was so stressful." -staff nurse
- c) "We've had patients who had cardiac arrests without the nurse knowing it. Most of the fatalities due to cardiac arrests happen from midnight to 8 am. Only one nurse is assigned to forty patients. - instructor
- d) " In our pediatric ward, One nurse cares for 40 babies, so, some babies have died from choking while being bottlefed. Ideally, the nurse should hold the bottle during feeding but since all 40 babies are fed at once, she leaves the bottle propped against a pillow. There have been two publicised cases of babies dying this way at the Lincoln but it has happened often enough in this hospital." -instructor
- e) "Cancer patients need us to talk to them but we cannot always do it because we don't have the time . During the day, the ideal ratio is one nurse to five patients but one nurse must take care of seven patients. Nurses get aggravated especially if the patient is very sick." staff nurse
- f) "You do short cuts, you choose priorities. We sometimes neglect patients physical hygiene. But we are dealing with lives and our priority is to save lives."

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g) "I have to find time in giving medications. For example, if I have to give medicines at one pm and again at 3 pm, I give one dosage at 2 pm. I know that patients are either underdosed and/or overdosed but it is better than not being able to give them at all." -staff nurse

The quality of patient care is further eroded when veteran nurses have to leave once their working visas expire.

THE FOLLOWING ARE TESTIMONIALS ABOUT THE NURSES :

a) "We had a 2-week orientation. Some hospitals tried to accomodate us while we were waiting for our work permit. They assigned us to offices to file papers. After a while, their funds ran out, and we had to work by relay: one group for two weeks to make sure we all got a paycheck."

b) "I I worked at a general hospital in our country. When I came here, I was supposed to got to Lincoln. But that suddenly changed and I and the others were assigned to a psychiatric hospital. We tried to protest , saying we had no psych experience but they said it was alright, psych nursing was easy. We were taken to three big buildings with barred windows. when we went from ward to ward, we stuck together---because we were shocked and frightened. The patients were so big and we were so small; They could easily pick us up and dash us against the wall. We noticed that the staff were quite untherapeutic. They would shout at the patients. And here we were---using our best communication skills, being so polite, so polite..."

c) "Working in intensive care unit, sincerely holding true to the ideals of the nursing profession as exhorted by our US textbooks in college, I literally broke my back as I constantly turned patients every two hours, in-between drawing blood gases suctioning and preparing intravenous fluids for the three patients in my caseload (the ideal is 1!!); I willed myself to start and finish my graduate studies so that like many American nurses, I could leave bedside nursing and teach and save my back."

d) "When I came here, nobody told me I had to take care of people with AIDS or give baths to 200-pound men or hospital supervisors telling me to take drugs if I get sleepy because my body system cannot function well if I work nights. You see, I couldn't take it especially after my first six months. By early morning, I'd be nauseous and would be vomiting from overwork and lack of sleep."

e) "Three Filipina nurses are said to have killed themselves already. The most recent happened at our hospital. She arrived in August 1985 and took the board exams. Afraid that she would fail, she did herself in around February. She's supposed to have left a note saying she was sure she had failed and she simply could not go home to tell her parents. Perhaps she thought she'd have to go home immediately if she failed. Perhaps she thought she would be deported right there and then... I met her a couple of times. She was 27 or 28 years old, petite, long-haired very shy... She was said to have been a really good student ... When I was told about her suicide, I was shocked. She had been here for a year. I had just been here four months. She was worried about the same things I was. I wondered if my reaction to these problems as time passed would be like hers: SUICIDE

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II. The Perspective :

Foreign nurses were imported to fill the gap that is now ever-widening between the demand and supply of nurses. Sources claim that they make up 23% of the workforce, majority of them are H-1 visa holders. It is estimated that 800 nurses' visas were due to expire at the end of 1988 in New York City.

Even as the shortage stresses them out, they continue to be hard-working professionals with a Western type of education taking pride in quality patient care. Proving their professional competence and commitment, they have evoked admiration and praise from patients they serve as well as from their employers, supervisors and peers.

However, the quality of patient care is eroded when in the face of the shortage, the veteran foreign nurses have to leave when their visas expire.

Further, the foreign nurses are placed in a position where their easy availability and accessibility may in the long term undermine the movement for better wages, benefits and working conditions for nurses in general.

Any tensions between foreign and domestic nurses can be used by management to further slash jobs and slow down any acceleration if at all, in wages.

Nurses are an essential resource for hospitals and the nation's health. Addressing their needs and aspirations including those of foreign nurses realistically and examining their work conditions meaningfully are pre-requisites for high quality patient care now and in the future.

A comprehensive approach to the crisis in nursing is in order, one that takes into consideration the need to market nursing as an attractive career option; that develops strategies to recruit and retain nurses as hospital employees; that takes into consideration the need of nurses to gain professional satisfaction in their career choice; that considers strategies for pay equity in the profession; that recognizes the role that foreign workers have played in alleviating the crisis and consequently addresses their welfare.

For their part, foreign nurses are committed to the ideals of their sisters in the same profession and therefore are committed to working hand in hand with their sisters to advance the struggle of nurses for a long while to come.

III. H. R. 1507

An act to amend the Immigration and Nationality Act to provide for special immigrant status for certain H-1 nonimmigrant nurses and to establish conditions for the admission, during a 5-year period, of nurses as temporary workers.

H.R. 1507 is one such concretization of a comprehensive approach to solve the crisis in nursing.

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It begins to establish, for the first time, some criteria that hospitals must adopt to recruit and retain American nurses.

Let us examine the following provisions:

a) An Amendment to the Immigration and Nationality Act to provide for special immigrant status for nurses holding H-1 visas. RN's who entered the U.S. before January 1, 1988 on H-1 visas and whose visa has not expired will be given permanent status along with members of their immediate family.

This means that foreign workers would not be threatened by the contractual nature of their stay into not participating in the struggles of the workforce to improve the work and life conditions of nurses in general even as they strive to deliver the highest quality of care.

b) A commission to be established including trade unions representing nurses to advise the Secretary of Labor regarding criteria to be met by hospitals before they are allowed to continue to recruit from abroad.

- b.1 such recruitment must not adversely affect the wages of other RN's as foreign nurses must be paid at the prevailing wage rate at the facility.
- b.2 an institution may not recruit RNs as strikebreakers.
- b.3 an institution must demonstrate that it is taking significant steps to recruit and retain RNs. It may do so by:
 - paying more than the wage rate prevailing in the community
 - providing for salary advancement
 - providing help for RNs to free them of non-nursing duties, etc.

Such measures would protect the interests of mainstream nurses while ensuring that foreign nurses would not be exploited by their employers.

c) A pilot visa program for foreign nurses entering the US after January 1988 for a maximum of five years.

With this provision, foreign nurses entering the US are aware at the outset of the limitation of their stay and are better-prepared for the restrictions on their stay.

d) The facility operates a Training Program for nurses.

- d.1 The final determination as to whether a facility has met this criteria would be determined by the Secretary of Labor.

The nursing profession would be greatly helped by this imperative on the employers to set aside funds for the training of nurses.



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This statement was prepared by the **FILIPINO NURSES ORGANIZATION**

The Filipino Nurses Organization was borne out of a crying need to advance the interests of foreign nurses, particularly the Filipino nurses and promote their rights and welfare. It seeks to raise the consciousness of the Filipino nurses and organize them to the kinds of problems they now face. It works in solidarity with unions, professional associations and immigrant counseling groups towards achieving better work and life conditions for nurses and migrant workers in the country.

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Region 5

Jo Cecelia Moore
Region 6

William Crotty
Region 7

Roger E. Benson
Region 8

Nelia Cardus
Region 9

Ken Robertson
Region 10

Herb Goodfriend
Region 11

David Greene
Region 12

Trustees:

Joan A. Brewster
 Jack Marsch
 Mary Frances Welch

STATEMENT BY THE
 NEW YORK STATE PUBLIC EMPLOYEES FEDERATION

to the

HOUSE JUDICIARY COMMITTEE
 SUBCOMMITTEE ON IMMIGRATION, REFUGEES
 AND INTERNATIONAL LAW

May 31, 1989

The Public Employees Federation pledges its organizational network in supporting the legislation that will allow foreign nurses already working in the country to become permanent residents.

The Public Employees Federation is composed of 59,000 professional, technical and scientific employees of the Office of Mental Hygiene, Office of Mentally Retarded and Developmental Disabilities, New York State Health Department, Corrections, Division of Youth, Division of Alcohol and Substance Abuse, State University of New York and several other agencies of the State of New York. About 9,000 - the largest sector among the membership - are nurses. About one third of its population are foreign nurses, most of whom are H-1 visa holders.

PEF realizes the implications of this legislation (H.R.1507) as it addresses the problems that the New York State nurses are encountering as well as on the quality of health care delivery in the state. The New York State nurses are not exempt from the debilitating conditions brought about by the nation-wide Nursing Shortage.

A nurse hurled across the examination room by a violent patient broke her pelvis. Another nurse dislocated her shoulder while trying to restrain a confused patient. And yet, in another incident, a nurse was seriously injured when a patient suddenly swung an office chair at her. These are not just stories, these are REAL incidents. In a large

state hospital, a total of 135 injuries were reported in a one-year study conducted last January 1989; nursing staff sustained 120 of these injuries.

These occurrences have a direct relation to the poor staffing patterns in the state facilities. Expressed in numbers a nurse would be taking care of three to four wards or an average of 120 patients.

Since about five years ago, New York State facilities have turned to foreign nurse recruitment programs to place much needed additional staff in their units. Despite this, OMRDD reported a vacancy rate of 25% in registered position as of last year - a rate tremendously higher than that of the national rate which is 11%.

New York State nurses have to contend with forced overtime and being assigned to a work area other than her usual. Coupled with this situation is the pressure that other agencies wish to exert in fulfilling documentation standards. The nurse then becomes over-burdened with paperwork.

And who suffers? Not only the nurses but also the clientele she wished to serve. New York State nurses care for patients who are emotionally ill and mentally retarded. Many of these patients have dual-diagnosis and drug-induced psychosis or other drug-related problems. Only quality care, that which involves a great deal of direct nursing care and supervision, will treat this type of clientele. There is always the goal that re-admissions be prevented or

more-so called the "Revolving Door Syndrome" be just a myth.

New York State nurses are underpaid. Based on comparable worth studies which takes into consideration experience, education and actual work performance - nurses , in general, are paid less. And when NYS nurses are compared to other health-care professionals and other registered nurses employed in the private sector, NYS nurses' salaries are way below.

NYS nurses still have to contend with the lack of opportunities in career advancements. There is limited upward mobility existing in the State System. The NYS nurses find themselves with insufficient continuing educational programs.

Recruitment and retention is basically the problem that behooves the nursing profession. It is understandable that nurses leave their profession to seek more paying and less hazardous jobs. Our high school graduates realizes that Nursing is not an attractive career option.

PEF is aware of the Nursing Shortage and its implications - much so with the immigration policy which limits the stay of our veteran nurses. We urge that passage of the HR 1507 as it also begins to establish - for the first time - some criteria that hospitals must adopt to recruit and retain American nurses.

HR 1507 states that a Commission should be established including trade unions representing nurses to advise the Secretary of Labor regarding criteria to be met by hospitals

before they are allowed to continue to recruit from abroad. It further states that an institution must demonstrate that it is taking significant steps to recruit and retain RNs. It may do so by: (1) paying more than the wage rate prevailing in the community, (2) providing for salary advancement, (3) providing help for RNs to free them of non-nursing duties. and (4) operating a training program for nurses or personnel in the health field, eg. licensed practical nurses and therapy aides. HR 1507 starts to establish a comprehensive policy to alleviate the country's Nursing Crisis and therefore PEF strongly supports it.

SNJHC SOUTHERN NEW JERSEY HOSPITAL COUNCIL

384 South White Horse Pike
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JUN 22 1989

An Affiliate of the
New Jersey Hospital Association

Dawn E. Perrotta
Executive Director

June 20, 1989

The Honorable Bruce A. Morrison
Chairman, House Judiciary Subcommittee on
Immigration, Refugees, and International Law
330 Cannon House Office Building
Washington, D.C. 20515

Dear Representative Morrison:

Testimony regarding H.R. 1507, the "Immigration Nursing Relief Act of 1989" was recently submitted to you by Carol Patten on behalf of the Raritan Bay Medical Center and the New Jersey Hospital Association (NJHA). Unfortunately, a comment regarding a provision of importance to New Jersey hospitals was inadvertently omitted. I believe that NJHA will be submitting an addendum to the testimony.

As Executive Director of the Southern New Jersey Hospital Council, which represents hospitals in the southern half of the State, I would also like to call your attention to the provision that could present a problem to southern New Jersey hospitals, as well as hospitals throughout the State.

As contained in Sec. 3.(b)(C)(ii) of the bill (page 7, lines 4-6), one of the options that would "be considered a significant step reasonably designed to recruit and retain registered nurses" reads as follows:

"Paying registered nurses at wages at a rate above the prevailing wage rate for registered nurses in geographic area."

Since the bill is designed to look at nursing shortage areas according to Metropolitan Statistical Areas (MSAs), many New Jersey hospitals that fall within the Philadelphia and New York City MSAs would be hurt by a wage comparison with these areas.

Although the majority of hospitals in New Jersey have provided significant and frequent salary increases to their nurses over the past years, our hospitals still lag behind Philadelphia and New York City hospitals by approximately \$5,000 annually. As you may be aware, New Jersey hospitals are unable to arbitrarily raise their rates. Rates are regulated by the New Jersey Hospital Rate Setting Commission, a board set up to approve or deny rate increase requests.

We would, therefore, appreciate the addition of language to H.R. 1507 that would advise the Secretary of Labor that when looking at wages in competing metropolitan areas consideration should be given to 1) the historical prevailing wage rate in the state (not the entire MSA) and 2) States that determine hospital rates through such unique entities as hospital rate setting commissions.

Thank you for your consideration and any assistance that you may be able to provide regarding this point. Please call me at (609)768-2124 if you have any questions. Thank you, again, for all your efforts on this necessary and welcomed legislation.

Sincerely,

Dawn Perrotta

Dawn E. Perrotta
Executive Director

